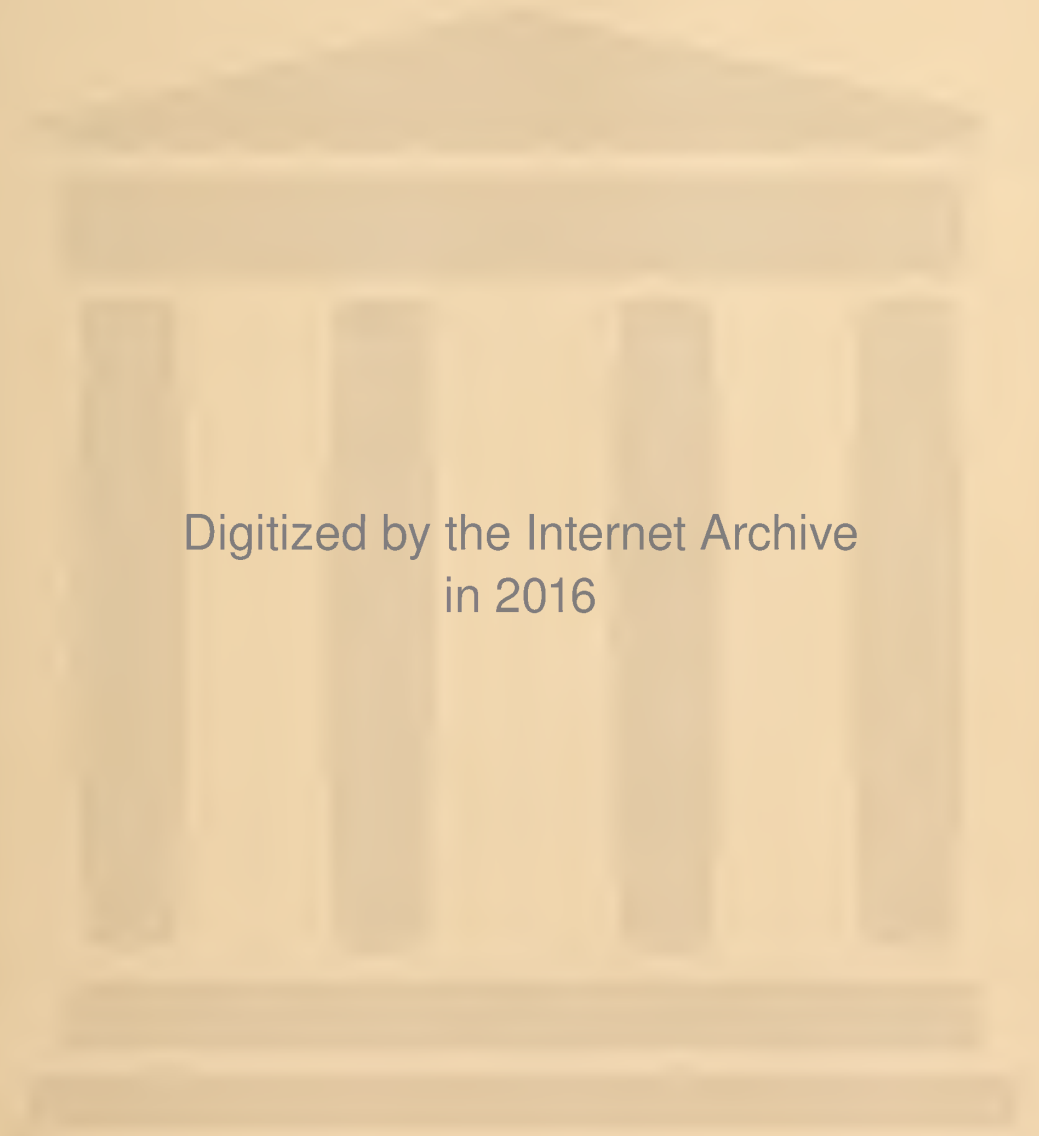


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- This index is arranged under the following headings:
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Key to Abbreviations in This Index

- Or.—Original Article.
- C. R.—Case Report.
- B. M.—Bedside Medicine.
- Ed.—Editorial.
- E. C.—Editorial Comment.
- C. N.—Clinical Notes.
- L. M. H.—Lure of Medical History.

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Moore, Grace
Pelligrini, Violet
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Vincent V. Suglian, M. D.

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OTOLARYNGOLOGY

John H. Childrey, M. D.
Ernst Wolfes, M. D.



MEMBERSHIP ROSTER : C. M. A.

COUNTY SOCIETIES INDICATED BY KEY NUMBERS

This roster gives the list of members for the year 1936. Deceased members are indicated by *.

KEY NUMBERS FOR COUNTY MEDICAL SOCIETIES

1. Alameda County.
2. Butte County.
3. Contra Costa County.
4. Fresno County.
5. Humboldt County.
6. Imperial County.
7. Kern County.
8. Kings County.
9. Lassen-Plumas-Modoc Counties.
10. Los Angeles County.
11. Marin County.
12. Mendocino-Lake Counties.
13. Merced County.
14. Monterey County.
15. Napa County.
16. Orange County.
17. Placer-El Dorado-Nevada-Sierra Counties.
18. Riverside County.
19. Sacramento County.
20. San Benito County.
21. San Bernardino County.
22. San Diego County.
23. San Francisco County.
24. San Joaquin County.
25. San Luis Obispo County.
26. San Mateo County.
27. Santa Barbara County.
28. Santa Clara County.
29. Santa Cruz County.
30. Shasta County.
31. Siskiyou County.
32. Solano County.
33. Sonoma County.
34. Stanislaus County.
35. Tehama County.
36. Tulare County.
37. Ventura County.
38. Yolo-Colusa-Glenn Counties.
39. Yuba-Sutter Counties.

COUNTY SOCIETY MEMBERSHIP TOTALS

(Year 1936)

Active Members in County Societies

Alameda County	476
Butte County	24
Contra Costa County	49
Fresno County	112
Humboldt County	30
Imperial County	27
Kern County	48
Kings County	15
Lassen-Plumas-Modoc Counties	11
Los Angeles County	2200
Marin County	40
Mendocino-Lake Counties	19
Merced County	28
Monterey County	51
Napa County	34
Orange County	109
Placer-El Dorado-Nevada-Sierra Counties	30
Riverside County	69
Sacramento County	143
San Benito County	7
San Bernardino County	137
San Diego County	258
San Francisco County	812
San Joaquin County	98
San Luis Obispo County	29
San Mateo County	58
Santa Barbara County	102
Santa Clara County	171
Santa Cruz County	30
Shasta County	15
Siskiyou County	15
Solano County	26
Sonoma County	54
Stanislaus County	40
Tehama County	11

Tulare County	38
Ventura County	35
Yolo-Colusa-Glenn Counties	26
Yuba-Sutter Counties	15

Active members	5492
Associate members	6
Retired members	60
Honorary members	9

Total members 5567

Sixty-five members died during the year 1936.

Note.—The California Medical Association by-laws provide for an annual directory. Because every member receives the annual directory of the Board of Medical Examiners of the State of California, and in order to avoid the great cost of duplication of such a directory, the California Medical Association Council has decided to print in the official journal a simple roster of members, giving for each member the city or place of residence, with a key number to indicate the county medical society in which membership is held. For additional information concerning school of graduation, etc., the State Medical Board directory or the central office of the California Medical Association should be consulted. Errors in the list here printed should be promptly reported to the central office of the California Medical Association, Four Fifty Sutter, San Francisco.

I. ACTIVE MEMBERS

— A —

NAME	CITY	COUNTY SOCIETY NO.
Abbott, C. L.,	Oakland	1
Abbott, C. N.,	Ontario	21
Abbott, F. F.,	Ontario	21
Abbott, G. K.,	Ukiah	12
Abbott, L. C.,	San Francisco	23
Abbott, U. S.,	Richmond	3
Abdun-Nur, A. S.,	Los Angeles	10
Abowitz, J.,	Los Angeles	10
Abraham, H.,	Los Angeles	10
Abraham, S. V.,	Los Angeles	10
Abraham, V. R.,	Long Beach	10
Abrahamson, M. J.,	Los Angeles	10
Abrons, Harry,	Berkeley	1
Achenbach, L. W.,	Ventura	37
Adams, B. A.,	San Leandro	1
Adams, B. O.,	Riverside	18
Adams, B. W.,	Oakland	1
Adams, E. L.,	Galt	19
Adams, J. H.,	Oakland	1
Adams, L. P.,	Escondido	22
Adams, L. P.,	Oakland	1
Adams, W. C.,	Oakland	1
Adelstein, L. J.,	Los Angeles	10
Agmar, A. R.,	San Francisco	23
Ahlem, J. E.,	Livermore	1
Ahrens, C. L.,	Artesia	10
Ainley, F. C.,	Los Angeles	10
Aird, J. L.,	Manhattan Beach	10
Aitken, H. C.,	Berkeley	1
Akesson, H. N.,	Oakland	1
Alanson, M. R.,	San Francisco	23
Albert, J. A.,	Oroville	2
Albert, W.,	Los Angeles	10
Alberty, W. M.,	East San Diego	22
Albi, P.,	San Francisco	23
Alcazar, I.,	Los Angeles	10
Alcon, D. N.,	Los Angeles	10
Alden, B. F.,	San Francisco	23
Alden, E.,	Los Angeles	10
Alden, W. C.,	Pasadena	10
Alderson, H. E.,	San Francisco	23
Alderson, V. G.,	Oakland	1
Aldrich, W. S.,	Los Angeles	10
Alesen, L. A.,	Los Angeles	10
Alexander, A. A.,	Oakland	1
Alexander, E.,	Oakdale	34
Alexander, E. W.,	San Francisco	23
Alexander, J. H.,	Chico	2
Algee, M. J.,	Compton	10
Allan, J. T. M.,	Los Angeles	10
Allen, A.,	San Pedro	10
Allen, A. B.,	Los Angeles	10
Allen, C. L.,	Los Angeles	10
Allen, C. S.,	Los Angeles	10
Allen, D. M.,	Oakland	1
Allen, E. G.,	Patterson	34
Allen, H. W.,	San Francisco	23
*Allen, J.,	Raymond	4
Allen, J. R.,	Los Angeles	10
Allen, M. R.,	Fairfax	11
Allen, O. K.,	San Francisco	23
Allen, P. K.,	San Diego	22
Allen, R. E.,	Reedley	4
Allen, R. W.,	Huntington Park	10
Allen, W. B.,	Oakland	1
Aller, D. I.,	Fresno	4
Allington, H. V.,	Oakland	1
Allison, B. S.,	Long Beach	10
Allison, C. N.,	San Diego	22
Allum, A. W.,	Glendale	10
Almada, A. A.,	Sacramento	19
Alsberge, E. W.,	Glendale	10
Alsberge, R. C.,	Santa Cruz	29
Alter, S. M.,	Los Angeles	10
Althausen, T. L.,	San Francisco	23
Alvarez, L. F.,	Los Angeles	10
Alward, H. C.,	Los Angeles	10
Amaral, E. A.,	San Jose	28
Ambrose, C. S.,	Los Angeles	10
*Ames, E. W.,	Los Angeles	10
Ammann, F. X., Jr.,	Los Angeles	10
Amsbaugh, A. E.,	San Francisco	23
Amthor, J. G.,	El Monte	10
Amyes, H. W.,	Huntington Park	10
Anders, J. C.,	San Diego	22
Anderson, A. C.,	Petaluma	33
Anderson, A. E.,	Fresno	4
Anderson, A. V.,	Pasadena	10
Anderson, B. N.,	Burbank	10
Anderson, C. M.,	Hermosa Beach	10
Anderson, C. R.,	Los Angeles	10
Anderson, C. W.,	Bishop	10
Anderson, E. DeM.,	San Luis Obispo	25
Anderson, E. F.,	San Francisco	22
Anderson, E. L.,	Los Angeles	10
Anderson, F. N.,	Los Angeles	10
Anderson, F. R.,	Campbell	28
Anderson, H., Jr.,	Los Angeles	10
Anderson, H. C.,	Pomona	10
Anderson, H. E.,	Culver City	10
Anderson, H. H.,	San Francisco	23
Anderson, J. F.,	Los Angeles	10
Anderson, J. G.,	Petaluma	33
Anderson, N. F.,	Los Angeles	10
Anderson, O.,	Santa Monica	10
Anderson, S. B.,	Burbank	10
Anderson, S. C.,	Glendale	10
Anderson, W. N.,	Los Angeles	10
Anderton, H. S.,	San Diego	22
Andrews, A. V.,	Livingston	13
Andrews, C. B.,	Sonoma	33
Andrews, H.,	Los Angeles	10
Andrews, H. F.,	San Diego	22
Andrews, H. J.,	Hollywood	10
Andrews, J. N.,	Los Angeles	10
Andrews, V. L.,	Los Angeles	10
Andrews, W. A.,	Yucaipa	21
Andrus, L. M.,	King City	14
Ankele, C. W.,	Sacramento	19
Annis, A. J.,	Los Angeles	10
Anthony, E. H.,	Los Angeles	10
Anton, F. L.,	Los Angeles	10
Appeldorn, H. H.,	Oakland	1
Apple, W. W.,	El Centro	6
Arbuthnot, R. E.,	Glendale	10
Arehart, A. A.,	Monterey	14
Arkush, A. S.,	Santa Monica	10
Armen, G. H.,	Los Angeles	10

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Armitstead, R. B.,	Ventura	37	Barbanell, R. R.,	Los Angeles	10	Bell, H. G.,	San Francisco	23
Armstrong, E. L.,	Los Angeles	10	Barber, E. M.,	Oakland	1	Bell, H. W.,	Bakersfield	7
Armstrong, M. I.,	Berkeley	1	Barber, P. S.,	Porterville	36	Bell, M. T.,	Ventura	37
Arnett, L. A.,	Waterford	34	Barbour, N. P.,	Stockton	24	Bell, T. F.,	Oakland	1
Arnold, F. L.,	Long Beach	10	Barclay, H. A.,	San Diego	22	Bell, W. L.,	Oakland	1
Arnold, H. J.,	San Jose	23	Bardill, J. W.,	Ventura	37	Bellin, J. J.,	Los Angeles	10
Arnold, H. R.,	San Francisco	23	Barkan, H.,	San Francisco	23	Belove, B.,	Los Angeles	10
*Arnold, M. H.,	San Diego	22	Barkan, O.,	San Francisco	23	Belt, A. E.,	Hollywood	10
Arnold, W. F.,	Long Beach	10	Barker, H. E.,	Ventura	37	Belt, R. L.,	Montrose	10
Arnot, P. H.,	San Francisco	23	Barker, J. L.,	Brawley	6	Beltz, D.,	Lodi	24
Arnov, B.,	Los Angeles	10	Barlow, T. H.,	Long Beach	10	Bender, W. L.,	San Francisco	23
Arthurs, E.,	San Francisco	22	Barlow, W. J.,	Los Angeles	10	Bendlage, G. A.,	Long Beach	10
Ash, R. L.,	San Francisco	23	Barmore, M. G.,	Calverton	6	Benner, E. A.,	San Mateo	26
Ashcroft, F. E.,	Chula Vista	20	Barnard, F. S.,	Los Angeles	10	Bennett, C. B.,	Berkeley	1
Ashley, K. C.,	Huntington Park	10	Barnard, H. D.,	Los Angeles	10	Bennett, C. L.,	Los Angeles	10
Ashley, N. N.,	Oakland	1	Barnard, H. D.,	Los Angeles	10	Bennett, C. R.,	Compton	10
Ashley, R. E.,	San Francisco	23	Barnard, L. B.,	Oakland	1	Bennett, D. W.,	San Francisco	23
Askey, E. V.,	Los Angeles	10	Barnes, J. W.,	Stockton	24	Bennett, E. L.,	Fresno	4
Askey, J. M.,	Los Angeles	10	Barnes, L. B.,	Newcastle	17	Bennett, E. S.,	Olive View	10
Atkinson, C. E.,	Banning	13	Barnes, P. D.,	Loomis	17	Bennett, L. B.,	San Pedro	10
Atkinson, D. W.,	San Francisco	23	Barnes, R. D.,	Los Angeles	10	Bennett, L. C.,	Los Angeles	10
Atkinson, R. C.,	Colfax	17	Barnes, S. W.,	Los Angeles	10	Bennett, M. C.,	Berkeley	1
Atsatt, R. F.,	Santa Barbara	27	Barnes, W. H.,	Oakland	1	Bennett, M. G. E.,	El Monte	10
Atteberry, C. V.,	Inglewood	10	Barnett, E. D.,	Santa Rosa	33	Bennett, W. W.,	Los Angeles	10
Attwood, W. G.,	Los Angeles	10	Barnett, G. D.,	San Francisco	28	Bennette, M. A.,	San Bernardino	21
Attwood, A. C.,	Chouchoilla	13	Barnhart, W.,	Los Angeles	10	Bennetts, F. A.,	Los Angeles	10
Attwood, H. A.,	Riverside	18	Baron, P. P.,	Alameda	2	Benninger, C.,	Jr., Oroville	2
Audrain, L. C.,	Los Angeles	10	Barr, A. L.,	San Diego	22	Benninghoven, C. D.,	San Mateo	26
Austin, F. O.,	Escondido	22	Barr, W. T.,	Fresno	4	Benson, C. B.,	Modesto	34
Austin, L. C.,	Los Angeles	10	Barrett, G. M.,	San Francisco	23	Benson, E. H.,	Jr., Berkeley	1
Austin, R. E.,	Coronado	22	Barrette, L. C.,	Sacramento	19	Benton, J. J.,	Oakland	1
Austin, T. C.,	Pasadena	10	Barrette, P. C.,	San Jose	28	Bepier, A. C.,	San Francisco	23
Avery, J. W.,	Hollywood	10	Barron, A.,	Stockton	24	Berauer, J. M.,	Los Angeles	10
Avery, W. J.,	Fresno	4	Barron, H. C.,	Jr., Escondido	22	Berg, A.,	San Francisco	23
Axline, J. T.,	North Hollywood	10	Barron, H. M.,	Boston, Mass.	10	Berg, G. O.,	Hollywood	10
Ayer, E. W.,	Oakland	1	Barrow, J. V.,	Los Angeles	10	Berge, F. E.,	Los Angeles	10
Ayers, T. F.,	San Francisco	23	Barrow, W. H.,	San Diego	22	Berger, A. A.,	San Francisco	23
Ayres, S., Jr.,	Los Angeles	10	Barry, G. L.,	San Jose	28	Bergman, R. T.,	Los Angeles	10
Ayres, W.,	Los Angeles	10	Bartle, I. B.,	San Luis Obispo	25	Bergmann, J. E.,	Santa Monica	10
Azevedo, J. A.,	Hayward	1	Bartholomew, J. Y.,	San Francisco	23	Bergstrom, F. K.,	Los Angeles	10
Azevedo, J. L., Jr.,	Modesto	34	Bartholomew, T. E.,	Calverton	6	Berkes, H. A.,	Hollywood	10
Azevedo, M. L.,	Sacramento	19	Bartlett, C. L.,	Pasadena	10	Berkley, H. K.,	Los Angeles	10
- B -			Bartlett, E. I.,	San Francisco	23	Berkove, A. B.,	Oakland	1
Babcock, D. W.,	Placerville	19	Barton, E. W.,	Alhambra	10	Berkove, S. E.,	Oakland	1
Babcock, E. S., Jr.,	Sacramento	19	Bascom, F. S.,	Oakland	1	Berman, P.,	Los Angeles	10
Babcock, J. W.,	Placerville	19	Bates, C. E. H.,	San Francisco	23	Bernardini, C. V.,	San Diego	22
Babcock, L. G.,	Vernon	10	Bathurst, E. W.,	Etna	31	Berne, C. J.,	Los Angeles	10
Babcock, R. A.,	Willits	12	Baughman, W. H.,	Oakland	10	Bernstein, A.,	San Francisco	23
Babienko, A. T.,	San Diego	22	Baumgartner, C. J.,	Los Angeles	10	Bernstein, M. M.,	Los Angeles	10
Babington, S. H.,	Berkeley	1	Bautista, M. D.,	Stockton	22	Berry, B. S.,	San Francisco	27
Baccus, C. F.,	Woodstock, Ill.	10	Baxter, C. P.,	San Diego	24	Bertero, J.,	Santa Maria	27
Bacher, J. A.,	San Francisco	23	Baxter, F. S.,	Oakland	1	Bertola, M.,	San Francisco	23
Bachhuber, C. A.,	Los Angeles	10	Bay, M. W.,	Los Angeles	10	Best, E. J.,	San Francisco	23
Bachmann, G. W.,	Santa Monica	10	Bay, S. G.,	West Los Angeles	10	Bettercourt, M. F.,	Watsonville	29
Bacigalupi, A. A. J.,	San Francisco	23	Bayer, L. M.,	San Francisco	23	Bettin, M. E.,	Los Angeles	10
Bacon, L. C.,	Beverly Hills	10	Bayley, W. A.,	Los Angeles	10	Betts, I. H.,	Visalia	36
Bacon, S. K.,	Hollywood	10	Baylis, J. N.,	San Bernardino	21	Bewley, M. H.,	Los Angeles	10
Baer, H.,	Elsinore	18	Beach, E. W.,	Sacramento	19	Bicknell, H. E.,	Long Beach	10
Baetz, W. G.,	Huntington Park	10	Beall, M. E.,	Patton	21	Bierman, J. M.,	Helena, Montana	23
Bahrenburg, G. E.,	Bakersfield	7	Bear, N. K.,	Riverside	18	Bicler, H. G.,	Pasadena	10
Bailey, C. O.,	Los Angeles	10	Beard, E. A.,	Inglewood	10	*Bigby, M. H.,	Downey	10
Bailey, F. J.,	Red Bluff	35	*Beard, J. L.,	Martinez	3	Bigger, A. B.,	Chouchoilla	13
Bailey, T. E.,	San Francisco	23	Beardslee, A.,	San Francisco	23	Bilker, D.,	San Jose	28
Bailey, W.,	Los Angeles	10	Beardsley, J. R.,	San Diego	22	Billig, H. E.,	Jr., Los Angeles	10
Bailey, W. E.,	Los Angeles	10	Beasley, E. M.,	Santa Ana	16	Billingsley, U. C.,	Hayward	1
Baiocchi, A. J.,	San Jose	23	Beasley, H. E.,	Glendale	10	Bilon, L. V.,	Los Angeles	10
Baird, C.,	San Bernardino	28	*Beattie, H.,	Elk Grove	19	Bine, R.,	San Francisco	23
Baird, C. G.,	Santa Maria	27	Beattie, J. I.,	San Jose	28	Bingaman, E. W.,	Salinas	14
Baird, H. R.,	Sacramento	19	Beattie, W. A.,	Sacramento	19	Bingaman, W. H.,	Salinas	14
Baird, M. N.,	Redondo Beach	10	Beatty, H. J.,	Clinton, New Jersey	10	Bingham, E.,	Berkeley	18
Bak, E. W.,	Los Angeles	10	Beatty, J. D.,	Los Angeles	10	Binkley, R. W.,	Selma	4
Baker, C. D.,	Los Angeles	10	Beauchamp, H. H.,	Sacramento	19	Binkley, T.,	Sacramento	19
Baker, F.,	San Francisco	23	Beaudoux, H. A.,	Oakland	1	Bird, A. A.,	Oakland	1
Baker, G. L.,	San Francisco	23	Beaver, H. J.,	Palo Alto	28	Birkenstock, C. F.,	San Diego	22
Baker, H. V.,	Napa	15	Beaver, M. G.,	Redlands	21	Birnbaum, W. D.,	San Francisco	23
Baker, J. J.,	West Los Angeles	10	Beck, G. H.,	Glendale	10	Bishop, C. R.,	Long Beach	10
Baker, M. D.,	San Jose	28	Beck, H. H.,	Corning	35	Bishop, T. E.,	San Diego	22
Baker, R. W.,	Sunland	10	Beck, H. R.,	Los Angeles	10	Bishop, T. W.,	S. Pasadena	10
Baker, W.,	Los Angeles	10	Beck, J. A.,	Salinas	14	Bittner, C. L.,	Sacramento	19
Baker, W. P.,	Santa Ana	16	Beck, J. E.,	Tulare	36	Bittner, L. H.,	Glendale	10
Bakewell, B.,	Santa Barbara	27	Becka, S. J.,	Los Angeles	10	Bittner, S. P.,	Glendale	10
Baldwin, A. K.,	Long Beach	10	Becker, G. H.,	San Francisco	23	Black, B. W.,	Oakland	1
Baldwin, B. L.,	Healdsburg	33	Becker, H. F.,	Los Angeles	10	Black, E. C.,	San Diego	22
Baldwin, J. G.,	Pasadena	10	Becker, W. A.,	Los Angeles	10	Black, H.,	Palo Alto	28
Baldwin, M. C.,	Riverside	18	Becker, W. N.,	Sacramento	19	Blackfield, H. M.,	San Francisco	23
Ball, D. R.,	Santa Ana	16	Beckett, W. A.,	Los Angeles	10	Blackman, W. H.,	Indio	6
Ball, F. L.,	Los Angeles	10	*Beckett, W. W.,	Los Angeles	10	Blackmun, E. L.,	Stockton	24
Ball, H. A.,	San Diego	22	Bedri, M. R.,	Los Angeles	10	Blackmun, R. L.,	Los Angeles	10
*Ball, J. D.,	San Francisco	22	Beche, J. L.,	Anaheim	16	Blackshaw, J. B.,	Sonoma	33
Ball, J. D.,	Santa Ana	16	Beche, L. J.,	Santa Maria	3	Blahnik, K. B.,	Pasadena	10
Ballard, C. H.,	Santa Monica	10	Beede, A. H.,	Walnut Creek	7	Blaine, E. S.,	Los Angeles	10
Ballard, S. E.,	Long Beach	10	Beekler, A. M.,	Santa Maria	27	Blaisdell, F. E.,	Jr., Watsonville	29
Balyeat, F. S.,	Los Angeles	10	Beem, M. D.,	West Los Angeles	10	Blaisdell, P. C.,	Pasadena	10
Bames, H. O.,	Los Angeles	10	Beerman, H. M.,	Los Angeles	10	Blake, C. R.,	Richmond	3
Bancroft, I. R.,	Los Angeles	10	Beeson, W. F.,	San Francisco	23	Blanchard, T. L.,	San Jose	28
Bandellier, R. H.,	Los Angeles	10	Beeson, H. O.,	San Bernardino	21	Blanc, C.,	Laguna Beach	10
Banks, A. E.,	San Diego	22	Behne, K. F.,	Los Angeles	10	Blank, B.,	Los Angeles	10
Banks, W. H.,	San Francisco	23	Behneman, H. M. F.,	San Francisco	23	Blatherwick, A. A.,	Los Angeles	10
			Behrendt, R. A.,	Los Angeles	10	Blatherwick, G. W.,	Los Angeles	10
			Beigelman, M.,	Los Angeles	10	Blecker, R. F.,	Fresno	4
			Belford, W. W.,	San Diego	22	Blemer, J. W.,	Diablo	3
			Bell, D. P.,	Oakland	1	Blevins, W. J.,	Woodland	38

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Blinn, J. F.,	Stockton	24	Bramkamp, A. L.,	Banning	18	Brunie, L. J.,	Pasadena	10
Bliss, G. L.,	Long Beach	10	Bramwell, L.,	Lake Arrowhead	21	Brunie, Y. S.,	Pasadena	10
Bliss, W. F.,	Pasadena	10	Branch, W. E.,	Los Angeles	10	Bruning, E. F.,	Santa Ana	16
Bloch, J. L.,	San Pedro	10	Brandel, H. M.,	Los Angeles	10	Brunn, H.,	San Francisco	23
Block, C. A.,	San Francisco	23	Brandenburg, K. C.,	Long Beach	10	Brusco, H. D.,	San Francisco	23
Blodgett, H. H.,	Beverly Hills	10	Brandes, L.,	Los Angeles	10	Brush, N. H.,	Santa Barbara	27
Blodgett, W. LeR.,	Calistoga	15	Brandt, F. H.,	Los Angeles	10	Brust, P. R.,	San Diego	22
Blond, H. H.,	Los Angeles	10	Brandt, G. C.,	Los Angeles	10	Bryan, L.,	San Francisco	23
Blondin, E. A.,	San Diego	22	Brannon, M.,	Merced	13	Bryant, D. C.,	Claremont	10
Blong, P. H.,	Alhambra	10	Bransford, S. G.,	Suisun	32	Bryant, H. E.,	Los Angeles	10
Blood, J. N.,	Redwood City	26	Bransford, M. B.,	Vallejo	32	Buchanan, R. A.,	Lodi	24
Bloomfield, A. L.,	San Francisco	23	Brastad, J. P.,	Anaheim	16	Buchner, G. O. H.,	Bakersfield	7
Blossom, H. S.,	Patton	21	Brazelton, H.,	Oakland	1	Buck, L. W.,	Ross	23
Blum, S.,	San Francisco	23	Breck, L. W.,	Rochester, Minn.	11	Buckell, A. E. T.,	Oakland	1
Blumenthal, E. L.,	Oakland	1	Breitman, H. B.,	Los Angeles	10	Buckingham, J. R.,	Los Angeles	10
Boardman, W. W.,	San Francisco	23	Brem, W. V.,	Los Angeles	10	Buckley, T. I.,	Oakland	1
Bobbitt, A. N.,	Pasadena	10	* Brendel, F. P.,	Sacramento	19	Bucknam, R. W. E.,	Hollywood	10
Bobbitt, J. D.,	San Diego	22	Breslin, F. J.,	Los Angeles	10	Budd, J. W., Jr.,	Los Angeles	10
Bock, C.,	Los Angeles	10	Breuer, C. H.,	San Jose	28	Budge, E. S.,	Los Angeles	10
Bodlander, J. W.,	Los Angeles	10	Breuer, R. G.,	San Jose	28	Bull, E. C.,	San Francisco	23
Bodman, E. W.,	Pasadena	10	* Brewer, L. C.,	Los Angeles	10	Bullard, C. T.,	King City	14
Boe, M. R.,	Alameda	1	Breyer, J. H.,	Pasadena	10	Bulley, E. W.,	Gustine	26
Boeck, W. C.,	Los Angeles	10	Bricca, C. R.,	San Francisco	23	Bullis, J. A. E.,	Los Angeles	10
Boehm, C. A.,	San Francisco	23	Bricca, E. C.,	San Francisco	23	Bullis, R. O.,	Los Angeles	10
Boehm, M.,	Napa	15	Bridgman, J. G.,	San Mateo	26	Bullitt, J. B.,	San Jose	28
Boehmer, A. C.,	Lodi	24	Bridgman, O.,	San Francisco	23	Bullock, A. S.,	Alhambra	10
Boerlicke, C. C.,	Berkeley	1	Bridgman, W. R.,	Hanford	8	Bullock, L. T.,	Los Angeles	10
Boess, E. C.,	Riverside	18	Briggs, G. A.,	Sacramento	19	Bulpitt, H. G.,	Santa Monica	10
Boetticher, E. O.,	Los Angeles	10	Briggs, LeR. H.,	San Francisco	23	Bulpitt, J. M.,	Santa Ana	16
Boge, H. G. C.,	Oakland	1	Briggs, W. M.,	Monrovia	10	Bulpitt, P. A.,	Santa Monica	10
Bogen, E.,	Olive View	10	Briggs, W. R.,	Sacramento	19	Bulpitt, Z. E. N.,	Santa Ana	16
Bogle, S. S.,	Santa Rosa	33	Brigham, E.,	Dinuba	36	Bulson, C. H.,	Napa	15
Boland, A. E.,	Los Angeles	10	Brigham, F. O.,	Los Angeles	10	Bumgarner, J. W.,	Richmond	3
Bolander, L. P.,	Van Nuys	10	Brill, W.,	Los Angeles	10	Bumpus, H. C.,	Pasadena	10
Bolender, M. C.,	Walnut Creek	3	Brinckerhoff, E. E.,	Oakland	1	Bumpus, L. D.,	Beverly Hills	10
Boles, A.,	Oakland	1	Brinkman, W. F.,	Long Beach	10	Bunch, C. C.,	Los Angeles	10
Bolin, Z. E.,	San Francisco	23	Briner, C. C.,	Auburn	17	Bunnell, S.,	San Francisco	23
Bolinger, H. J.,	Lodi	24	Broadus, C. A.,	Stockton	24	Burby, J. J.,	San Bernardino	21
Boller, S.,	Los Angeles	10	Brock, L. H.,	San Francisco	23	Burchard, K. G. H.,	Los Angeles	10
Bollig, H. L.,	Los Angeles	10	Brockow, J. L.,	Los Angeles	10	Burchiel, C. M.,	San Jose	28
Bolognino, O. J.,	San Francisco	23	Brockway, A.,	Los Angeles	10	Burden, H. S.,	Sacramento	19
Bolstad, H. C.,	Oakland	1	Brodovsky, D.,	San Jose	28	* Burg, B. V.,	Oakland	1
Bolze, E. H.,	San Francisco	23	Broemser, M. A.,	San Jose	28	Burgan, J. H.,	Los Angeles	10
Bonar, P. A.,	San Francisco	23	Bronfeld, N.,	Los Angeles	10	Burge, M. H.,	Los Angeles	10
Bond, A. L.,	Lindsay	36	Brooks, C. S.,	El Centro	6	Burger, F. A.,	El Centro	6
Bond, F. M.,	San Diego	22	Brooks, E. R.,	Atascadero	1	Burger, T. O.,	San Diego	22
Bond, R. E.,	San Diego	22	Brooks, H. T.,	Alhambra	10	Burk, C. E.,	Roslyn, Washington	21
Bonesteel, H. T. S.,	Los Angeles	10	Brooks, LeR.,	San Francisco	23	Burk, E. E.,	Los Angeles	10
Bonfiglio, J.,	Hollywood	10	Bross, R. B.,	Venice	10	Burke, A. M. B.,	Alameda	1
Bonfiglio, V.,	Los Angeles	10	Broughton, G. A.,	Ventura	37	Burke, D. V.,	Berkeley	1
Bonn, H. K.,	Los Angeles	10	Brown, A.,	San Francisco	23	Burke, E. W.,	Redlands	21
Bonoff, K. M.,	Los Angeles	10	Brown, A. F.,	Los Angeles	10	Burke, G. R.,	Alameda	1
* Bonta, M. B.,	Los Angeles	10	Brown, A. L.,	Riverside	18	Burke, G. T.,	Pasadena	10
Bonthlus, A.,	Pasadena	10	Brown, A. L.,	San Francisco	23	Burkman, A.,	Los Angeles	10
Bonura, F.,	Los Angeles	10	Brown, B.,	Sacramento	19	Burkett, R. C.,	Napa	15
Bonynge, C. W.,	Los Angeles	10	Brown, B. C.,	Los Angeles	10	Burkhard, W. G.,	San Francisco	23
Boone, W. R.,	Berkeley	1	Brown, B. H.,	San Ysidro	22	Burks, F. L. R.,	Fresno	4
Boonshaft, L.,	Los Angeles	10	Brown, B. P.,	Los Angeles	10	Burlew, J. M.,	Santa Ana	16
Booth, M. M.,	St. Helena	15	Brown, C.,	San Francisco	23	Burlingame, R. W.,	San Francisco	23
Borden, F. W.,	San Jose	28	Brown, C. M.,	Los Angeles	10	Burnap, S. R.,	Los Angeles	10
Borley, R. D.,	Half Moon Bay	26	Brown, C. W.,	San Diego	22	Burnett, C. I.,	Susanville	9
Borley, W. E.,	San Francisco	23	Brown, C. W.,	San Diego	22	Burnham, C. J.,	Berkeley	1
Bormann, G. B.,	Hollywood	10	Brown, D. F.,	Redwood City	26	Burnham, C. J., Jr.,	Berkeley	1
Boscoe, A. R.,	Sacramento	19	Brown, E. O.,	Sacramento	19	Burnham, DeW. K.,	San Francisco	23
Boscoe, C. T.,	Oakland	1	Brown, F. A.,	Auberry	16	Burnham, P. S.,	Los Angeles	10
Boskowitz, G. H.,	San Francisco	23	Brown, F. A.,	Hayward	1	Burns, B. B.,	Pasadena	10
Bost, C.,	San Francisco	23	Brown, G. B.,	Oakland	1	Burns, E. M.,	Huntington Park	10
Bost, F. C.,	San Francisco	23	Brown, G. D.,	Pomona	10	Burns, G. C.,	Huntington Park	10
Bosworth, H. W.,	Los Angeles	10	Brown, G. W.,	Los Angeles	10	Burns, J. E.,	Huntington Park	10
Botsford, M. E.,	San Francisco	23	Brown, H. A.,	Berkeley	1	Burns, T. S.,	San Francisco	23
Bourbon, O. P.,	Los Angeles	10	Brown, H. A.,	San Francisco	23	Burnside, C.,	Hollywood	10
Bowen, A.,	Los Angeles	10	Brown, H. C.,	San Jose	28	Burrall, G. M.,	Los Angeles	10
Bowen, C. B.,	Oakland	1	Brown, H. V.,	Glendale	10	Burroughs, P. R.,	Santa Monica	10
Bowen, F. P.,	Los Angeles	10	Brown, J. M.,	Los Angeles	10	Burrows, C. A.,	Los Angeles	10
Bower, A. G.,	Glendale	10	Brown, J. M.,	Ferndale	5	Burrows, J. R.,	San Francisco	23
Bower, C. F.,	Long Beach	10	Brown, J. R.,	Los Angeles	10	Burrows, L. A.,	Los Angeles	10
Bowers, C. H.,	Los Angeles	10	Brown, L. E.,	Corona	18	Burrows, M. T.,	Pasadena	10
Bowers, P. E.,	Los Angeles	10	Brown, M. H.,	Los Angeles	10	Bursell, A.,	Mountain View	28
Bowers, W. S.,	Los Angeles	10	Brown, N. N.,	Bakersfield	7	Burtess, H. I.,	Santa Barbara	27
Bowles, A. M.,	Santa Rosa	33	Brown, P. K.,	San Francisco	23	Burton, F. A.,	San Diego	22
Bowles, F. H.,	Oakland	1	Brown, R.,	Santa Barbara	27	Burwell, L. C.,	Los Angeles	10
Bowman, P.,	West Los Angeles	10	Brown, R.,	San Francisco	23	Busby, J. L.,	Pasadena	10
Bowman, P. J.,	Fort Bragg	12	Brown, R. H.,	Pasadena	10	Bush, H. C.,	Livermore	1
Bowman, R. J.,	Los Angeles	10	Brown, T. H.,	Orland	38	* Buskirk, W. H.,	Los Angeles	10
Boyce, L.,	Los Angeles	10	Brown, W. H.,	Palo Alto	28	Bussey, D. G.,	Avalon	10
Boyce, W. A.,	Los Angeles	10	Browne, F. E.,	Los Angeles	10	Butka, L. J.,	Alhambra	19
Boyd, E. F.,	Los Angeles	10	Browne, G. C.,	Oakland	1	Butler, E.,	San Francisco	23
Boyd, E. G.,	Los Angeles	10	Brownfield, W. H.,	Los Angeles	10	Butler, F. O.,	Eldridge	33
Boyd, H. W.,	Los Angeles	10	Browning, C. F.,	Los Angeles	10	Butler, J. B. V.,	San Luis Obispo	25
Boyd, R. T.,	San Francisco	23	Brownlie, J. W.,	Vallejo	32	Butler, K. W.,	Madera	4
Boyd, T. O.,	Long Beach	10	Brownsberger, C. N.,	Glendale	10	Butler, O. W.,	Los Angeles	10
Boyd, W. H.,	Long Beach	10	Brownsberger, S. B.,	Los Angeles	10	Butler, W. D.,	San Luis Obispo	25
Boyer, H. R.,	Glendale	10	Bruck, E. L.,	San Francisco	23	Butt, E. G.,	Redondo Beach	10
Boyer, J. I.,	Long Beach	10	Bruckman, F. S.,	San Francisco	23	Butt, E. M.,	Los Angeles	10
Boyer, K. H.,	Los Angeles	10	Bruckman, H.,	San Jose	28	Butterfield, A. DeF.,	National City	22
Boyers, L. M.,	Berkeley	1	Bruff, W. C.,	Whittier	10	Butterfield, E. R.,	Burbank	10
Boyle, S. F.,	San Francisco	23	Bruln, M. R.,	Los Angeles	10	Butzin, T. A.,	Beverly Hills	10
Bradford, F. E.,	Los Angeles	10	Brull, A.,	Los Angeles	10	Byars, A. H.,	San Diego	22
Brady, A. L.,	San Rafael	11	Bruman, A. K.,	San Francisco	23	Byers, W. M.,	Van Nuys	10
Brady, J. F.,	Alameda	1	Brumbaugh, D. H.,	Redlands	21	Byington, P. C.,	Modesto	34
Bralthwalte, W. W.,	Beverly Hills	10	Brumwell, D.,	King City	14	Byron, R. L.,	Los Angeles	10
Bramhall, R. N.,	Sacramento	19	Brunemeler, E. H.,	Placentia	16	Byron, W. P.,	Lemoore	8

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
- C -								
Cady, D. W., Pasadena		10	Chaffin, G. L., Los Angeles		10	Cleave, D. C., San Francisco		23
Cady, F. P., Los Angeles		10	Chaffin, R. C., Los Angeles		10	Clecak, N. J., Oakland		1
Cahen, C. G., Los Angeles		10	Chaimov, A. S., San Francisco		23	Cleaves, M., La Crescenta		10
Cahoon, G. W., Los Angeles		10	Chain, J. N., Eureka		5	Clemmer, C. V., San Marino		10
Cain, E. F., Anaheim		16	Chalmers, J. F., La Jolla		22	Clemons, E. J., Los Angeles		10
Cain, W. T., Gardena		10	Chaloupka, H. R., Los Angeles		10	Cline, J. W., San Francisco		23
Calaway, A. A., Fresno		4	Chamberlain, B. H., Alhambra		10	Clock, C. J., Redlands		21
Caldwell, G. W., Los Angeles		10	Chamberlain, E. F., San Diego		22	Close, F. M., San Francisco		23
Caldwell, H. M., La Canada		10	Chamberlain, G. L., Oakland		1	Close, K. M., Los Angeles		10
Callander, C. L., San Francisco		23	Chamberlin, H. H., Glendora		10	Clough, F. E., San Bernardino		21
Callaway, A. A., Fresno		4	Chambers, S. O., Los Angeles		10	Clough, V. R., Long Beach		10
Callaway, J. W., La Jolla		22	Chamlee, W. F., Hanford		8	Coate, C. R., Whittier		10
Callaway, W. O., Burlingame		26	Champion, J. A., Colton		21	Coate, J. D., Oakland		1
Callison, F. W., San Francisco		23	Chandler, L. R., San Francisco		23	Coates, G. L., Jr., Martinez		3
Calvin, G. F., Oakland		1	Chaney, L. A., Los Angeles		10	Coats, E. A., Santa Cruz		29
Cameron, A. C., Los Angeles		10	Channell, W. L., Oakland		23	Cobb, V. M., Pasadena		10
Cameron, L. C., Santa Ana		16	Chapman, G. E., San Francisco		23	Cobbs, P. P., Los Angeles		10
Cameron, M. C., Los Angeles		10	Chapman, H. S., Stockton		24	Coblentz, L. B., San Francisco		23
Cameron, N. W. A., Los Angeles		10	Chapman, J. F., Pasadena		10	Coblentz, Z. B., San Francisco		23
Camp, J. W., La Habra		16	Chapman, J. L., Los Angeles		10	Cochran, G. H., Los Angeles		10
Campbell, C. C., Long Beach		10	Chapman, L. S., Los Angeles		10	Cochran, G. V., Oakland		1
Campbell, C. R., San Jose		28	Chapman, W. H., Blythe		13	Cochran, R. C., Yorba Linda		16
Campbell, D. McL., San Francisco		23	Chappell, A. E., Vallejo		32	Cocks, C. E., Oakland		1
Campbell, G. E., Pasadena		10	Chappell, G. E., Sacramento		19	Coe, H. C., Oakland		1
Campbell, H. S., Lindsay		36	Chappell, H. W., Los Angeles		10	Coeur-Barron, F. H., Los Angeles		10
Campbell, H. S., Los Angeles		10	Charles, H. L., Alhambra		10	Coffey, E. C., Orland		38
Campbell, J. R. U., Dunsmuir		31	Charlesworth, I. E., Imola		15	Coffey, G. C., Ventura		37
Campbell, J. V., Oakland		1	Charlton, A. T., Whittier		10	Coffey, S. E., Orland		38
Campbell, L. D., San Jose		28	Charlton, C. F., Pasadena		10	Coffey, W. B., San Francisco		23
Campbell, L. G., Pasadena		10	Charmak, D. D., San Francisco		23	Coffin, H. W., Los Angeles		10
Campbell, M., Los Angeles		10	Charnock, D. A., Los Angeles		10	Coghlan, C. C., Los Angeles		10
Campbell, McL., San Pedro		10	Chase, A. E., Santa Ana		16	Cohn, M., San Francisco		23
Campbell, M. P., San Francisco		23	Chase, A. S., Los Angeles		10	Cohn, A. L., San Francisco		23
Campbell, R., Los Angeles		10	Chase, E. M., Soledad		14	Cohn, H. J., San Francisco		23
Campbell, R. A., Los Angeles		10	Chase, F. H., Los Angeles		10	Cohn, J., San Francisco		23
Campiche, P. S., San Francisco		23	*Chase, R. E., Glendale		10	Cohn, J. L., Los Angeles		10
Canby, C. B., Van Nuys		10	Chavannes, V. C., Los Angeles		10	Cohn, M. L., San Francisco		23
Canelo, C. K., San Jose		28	Chavez, M., Los Angeles		10	Colburn, J. M., Riverside		18
Canfield, M. C., El Centro		6	Cheney, G., San Francisco		23	Colby, E. F., Bakersfield		7
Canfield, M. N., Redlands		21	Cheney, L. D., Los Angeles		10	Colby, E. G., San Diego		22
Cannon, F. M., San Rafael		11	Cheney, M. C., Berkeley		1	Cole, E. R., Sacramento		4
Cantarow, J. H., Los Angeles		22	Cheney, W. F., San Francisco		23	Cole, W., Long Beach		10
Cantoni, A. J., San Diego		22	Cherry, C. F., Los Angeles		10	Coleman, B. E., Los Angeles		10
Capp, C. S., San Francisco		23	Cherry, W. S., Rialto		21	Coleman, D. D., Alhambra		10
Card, T. A., Riverside		18	Chesbro, E. J., Gilroy		28	Coleman, E. H., Fresno		4
Carden, J. J., Honolulu, T. H.		1	Chessman, F. N., Los Angeles		10	Coleman, F. D., Los Angeles		10
Carey, H. B., San Francisco		23	Chiapella, J. O., Chico		2	Coller, G. J., Los Angeles		10
Carey, T. S., Los Angeles		10	*Chidester, W. C., San Mateo		26	*Collings, H. A., Susanville		9
Carey, W. W., Gridley		2	Childress, M. H., Ione		19	Collins, A. W., San Francisco		23
Carhart, E. C., Hollywood		10	Childrey, J. H., Menlo Park		27	Collins, C. D., Fresno		4
Carlile, M. N., Lakeside		22	Chilton, F. N., San Jose		28	Collins, D. C., Beverly Hills		10
Carlson, C. M., Santa Rosa		33	Ching, P. S., Fresno		4	Collins, F. K., Los Angeles		10
Carlson, E., San Francisco		23	Chipman, E. D., San Francisco		23	Collins, J. L., Turlock		34
Carlson, E. F., Fort Jones		31	Chipman, W. D., Los Angeles		10	Collins, M. C., Turlock		34
Carlson, F. J., Oakland		1	Chouret, E. E., Riverbank		34	Collins, W. H. L., Stockton		24
Carmack, J. C., San Bernardino		21	Christensen, A. C., Glendale		10	Collischonn, P., San Francisco		23
Carmichael, H., Sacramento		19	Christensen, E. L., Los Angeles		10	Colver, B. N., Glendale		10
Carpenter, F. L., Berkeley		1	Christensen, G. E., Los Angeles		10	Comfort, H. W., Fortuna		5
Carpenter, H. C., Berkeley		1	Christensen, W., Los Angeles		10	Commons, E. L., Los Angeles		10
Carpenter, H. L., Richmond		3	Christensen, W. M., Eagle Rock		19	Compton, C. S., Bakersfield		7
Carr, J. L., San Francisco		23	Christian J. T., Galt		19	Comstock, B. W., Los Angeles		10
Carroll, R. L., Los Angeles		10	Christie, R. C., Long Beach		10	Comstock, D. D., Los Angeles		10
Carroll, W. A., San Francisco		23	Christierson, S. von, San Francisco		23	Comstock, T. R., Los Angeles		10
Carson, A. B., Oakland		1	Christman, P. W., Sacramento		19	Condit, J. C., Oakland		1
Carson, D. A., San Francisco		23	Christopherson, E. H., San Diego		22	Condit, J. D., Pasadena		10
Carson, G. R., San Francisco		23	Church, C. H., Berkeley		1	Condon, W. R., Santa Cruz		29
Carter, A. E., North Hollywood		10	Church, I. O., Oakland		1	Conklin, C. M., Glendale		10
Carter, C. E., Pasadena		10	Church, M. V., Norwalk		10	Conlan, F. J. S., San Francisco		23
Carter, F. H., San Diego		22	Churchill, A. G., Coronado		22	Conlan, P. T., Los Angeles		10
Carter, H. R., Palo Alto		28	Churchill, J. F., San Diego		22	Conn, C. E., Hollywood		10
Carter, M. G., Los Angeles		10	Cieri, S., Oakland		1	Connell, DeB. W., Berkeley		1
Carter, R. A., Los Angeles		10	Ciley, H. A., San Jose		28	Connell, J. A., Riverside		18
Carter, R. H., Fresno		4	Citron, J. W., Oakland		31	Conner, A. W., San Jose		28
Carter, R. S., San Diego		22	Clark, C. W., San Rafael		11	Connor, C. L., San Francisco		23
Carter, W. E., San Francisco		1	Clark, D. G., Santa Paula		37	Conroy, B. J., Fairfax		11
Carter, W. N., Los Angeles		10	Clark, D. M., Santa Barbara		28	Conroy, T. F., Palo Alto		28
Cartmell, T. M., Los Angeles		10	Clark, E. B., Los Altos		27	Conser, W. H., Guadalupe		27
Caruso, T. D., Los Angeles		10	Clark, E. P., Los Angeles		10	Conzelmann, F. J., Stockton		24
Carver, W. F., Jr., Hollywood		10	Clark, F. A., Riverside		18	Cooder, H. R., Los Angeles		10
Cary, N. A., Berkeley		1	Clark, G. S., Los Angeles		10	Coodley, O., Los Angeles		10
Cary, R. J., Long Beach		10	Clark, H. E., Monterey		14	Cook, C. S., Los Angeles		10
Cary, W. S., San Francisco		23	Clark, H. S., Riverside		18	Cook, C. W., Los Angeles		10
Case, C. E., Santa Maria		27	Clark, I. S., Long Beach		10	Cook, E. D., Azusa		10
Case, L. W., Pomona		10	Clark, J. A., Gilroy		28	Cook, E. F., Los Angeles		10
Casey, H. A., Oakland		1	Clark, J. W., Santa Rosa		33	Cook, E. J., Los Angeles		10
Casey, T. J., Oakland		1	Clark, L. J., Hemet		18	Cook, E. P., San Jose		28
Caskey, C. R., Los Angeles		10	Clark, T. J., Oakland		1	Cook, J. D., Olive View		10
Cass, D., Los Angeles		10	Clark, V. G., San Diego		22	Cook, O. S., Sacramento		19
Cassady, E. S., San Pedro		10	Clark, W. A., Pasadena		10	Cook, W. C., Los Angeles		10
Cassell, I., San Jose		28	Clark, W. A., Holtville		6	Cook, W. P., Los Angeles		10
Castlehup, P., San Francisco		23	Clark, W. F., Los Angeles		10	Cooke, A. B., Los Angeles		10
Cates, H. B., Los Angeles		10	Clark, W. R. P., San Francisco		23	Cooke, W. C., San Diego		22
Catton, J., San Francisco		23	Clark, W. S., Ventura		37	Cooley, C. L., San Francisco		23
Cavanaugh, L. A., West Los Angeles		27	Clarke, A. F., Oakland		1	Coon, G. W., Riverside		18
Cecil, A. B., Los Angeles		10	Clarke, F. B., Long Beach		10	Cooper, A. J., San Diego		22
Cecil, J. E., Patton		21	Clarke, R. M., Los Angeles		10	Cooper, B., Arcata		5
Cerf, A. J., San Francisco		23	Clarke, W. T., Los Angeles		10	Cooper, C. L., Los Angeles		10
Chabanoff, E., San Francisco		23	Clay, H. E., San Francisco		23	Cooper, C. M., San Francisco		23
Chaffee, B. S., Long Beach		10	Clayton, J. H., Los Angeles		10	Cooper, F. G., Huntington Park		10
			Cleary, E. W., San Francisco		23	Cooper, G. P., Angels Camp		24
			Cleary, G. G., San Francisco		23	Cooper, H. J., Fresno		4
						Cooper, J. A., Modesto		34

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Cooper, T. E., <i>Davis</i>		38	Cunningham, R. L., <i>Berkeley</i>		1	Desch, W. D., <i>Oakland</i>		1
Cooper, W., <i>Palo Alto</i>		28	Cunningham, T. M., <i>La Mesa</i>		22	Desimone, L. O., <i>Los Angeles</i>		10
Copeland, E. K., <i>Woodland</i>		38	Cunningham, T. T., <i>Huntington Pk</i>		10	Desmond, M. A., <i>Santa Monica</i>		10
Copp, E. F. F., <i>La Jolla</i>		22	Cunningham, W. E., <i>Richmond</i>		3	Desparois, G. B., <i>Los Angeles</i>		10
Corbin, D. E., <i>San Diego</i>		22	Curdts, C. E., <i>Oakland</i>		1	Desrosier, G. W., <i>Colusa</i>		38
Cordes, F. C., <i>San Francisco</i>		23	Currey, H. M., <i>Santa Ana</i>		16	Desser, A. L., <i>Los Angeles</i>		10
Cordua, O. B., <i>San Diego</i>		22	Currie, A. H., <i>Los Angeles</i>		10	Dettling, F. E., <i>Los Angeles</i>		10
Cornell, H. D., <i>San Diego</i>		22	Curlin, A. R., <i>Milpitas</i>		28	De Vault, C. H., <i>Oakland</i>		1
Cornelle, J. G., <i>Berkeley</i>		1	Curtis, C. G., <i>Brea</i>		16	De Vigne, H. C., <i>Santa Barbara</i>		27
Cornett, W. F., <i>Pasadena</i>		10	Curtis, L. E., <i>Hetch Hetchy</i>		19	Devin, S. B., <i>Los Angeles</i>		10
Cornwall, T. W., <i>San Francisco</i>		23	Cushman, G. F., <i>San Francisco</i>		23	Dewey, E. B., <i>Pasadena</i>		10
Corr, W. P., <i>Riverside</i>		18	Cushman, R. A., <i>Talmage</i>		12	Dewey, E. T., <i>San Francisco</i>		23
Cortright, C. B., <i>Berkeley</i>		1	Custer, L. R., <i>San Francisco</i>		23	Dewey, H. G., <i>Yosemite</i>		13
Cosgrove, C. P., <i>Los Angeles</i>		10	Cutler, O. I., <i>Loma Linda</i>		21	Dick, P. J., <i>Oakland</i>		1
Cosgrove, J. B., <i>Los Angeles</i>		10	Cutter, R. K., <i>Berkeley</i>		1	Dickerson, D. G., <i>Los Angeles</i>		10
Coshow, G. H., <i>Carpinteria</i>		27	Cutting, J. A., <i>Agnew</i>		28	Dickerson, H. W., <i>San Diego</i>		22
Costa, F. J., <i>San Pedro</i>		10				Dickey, C. A., <i>San Francisco</i>		23
Costolow, W. E., <i>Los Angeles</i>		10				Dickey, C. D., Jr., <i>Los Angeles</i>		10
Cottle, C. C., <i>Los Angeles</i>		10				Dickie, W. M., <i>Berkeley</i>		1
Cottrell, C. C., <i>Scotia</i>		5				Dickinson, A. E., <i>Los Gatos</i>		28
Cottrell, E. L., <i>San Jose</i>		28				Dickinson, C. C., <i>McCloud</i>		31
Cottrell, J. C., <i>Long Beach</i>		10				Dickson, A. J., <i>Glendale</i>		10
Couey, E. J., <i>Fresno</i>		4				Dickson, E. C., <i>San Francisco</i>		23
Coughlin, J. H., <i>San Bernardino</i>		21				Didier, F. W., <i>Wheatland</i>		39
Coulter, J. D., <i>Portola</i>		9				Diederich, O. P., <i>Fresno</i>		4
Counter, C. E., <i>Loma Linda</i>		21				Diefenbach, W. E., <i>La Jolla</i>		22
Counter, H. M., <i>Buena Park</i>		16				Diepenbrock, A. B., <i>San Francisco</i>		23
Courville, C. B., <i>Los Angeles</i>		10				Diesner, H. G., <i>Sunnyvale</i>		27
Covault, W. I., <i>Costa Mesa</i>		16				Dieterle, K. L., <i>Los Angeles</i>		10
Cowan, A. B., <i>Fresno</i>		4				Dieterich, H., <i>Los Angeles</i>		10
Cowgill, C. H., <i>Huntington Park</i>		10				Dietz, H. L., <i>Oakland</i>		1
Cowin, C. C., <i>Hollywood</i>		10				Diggs, C. S., <i>Los Angeles</i>		10
Cowles, D. C., <i>Fullerton</i>		16				Dignan, H. H., <i>San Francisco</i>		23
Cox, B. E., <i>Coalinga</i>		4				Dillingham, F. S., <i>Los Angeles</i>		10
Cox, E. R., <i>Los Angeles</i>		23				Dillon, E. T., <i>Los Angeles</i>		10
Cox, G. W., <i>San Francisco</i>		23				Dillon, J. R., <i>San Francisco</i>		23
Cox, J. E., <i>Coalinga</i>		4				Dillon, V. M., <i>San Francisco</i>		23
Cox, T. J., <i>San Francisco</i>		23				Dispensa, J. G., <i>Santa Barbara</i>		27
Cox, W. J., <i>San Francisco</i>		23				Diven, G. R., <i>Los Angeles</i>		10
Coyle, J. D., Jr., <i>Sacramento</i>		19				Dixon, C. D., <i>Santa Monica</i>		10
Coyne, A. E., <i>Los Angeles</i>		10				Dixon, C. E., <i>Los Angeles</i>		21
Crabtree, E. G., <i>San Diego</i>		22				Dixon, H. B., <i>San Francisco</i>		23
Crabtree, E. H., <i>San Diego</i>		22				Doane, B. L., <i>Pasadena</i>		10
Crabtree, W. C., <i>San Diego</i>		22				Doane, C. P., <i>Fresno</i>		4
Craft, E. D., <i>Los Angeles</i>		10				Doane, F. L., <i>Red Bluff</i>		35
Crahan, M. E., <i>Los Angeles</i>		10				Doane, P. S., <i>Pasadena</i>		10
Craig, C. A., <i>Lakeport</i>		12				Dobson, L. G., <i>San Francisco</i>		23
Craig, J. B., <i>Uplands</i>		21				Dock, G., <i>Pasadena</i>		10
Craig, L. G., <i>Pasadena</i>		10				Dock, W., <i>San Francisco</i>		23
Craig, R. G., <i>San Francisco</i>		23				Dockweiler, R. R., <i>Los Angeles</i>		10
Craig, S. A., <i>Ontario</i>		21				Dodge, W., <i>Los Angeles</i>		10
Craik, C. W., <i>Venice</i>		10				Doehring, C. F., <i>Pasadena</i>		10
Crane, C. C., <i>San Francisco</i>		23				Dolan, P. E., <i>Livermore</i>		1
Crane, E. H., <i>Inglewood</i>		10				Dole, K. L., <i>Redlands</i>		21
Crane, H. W., <i>Berkeley</i>		1				Dolley, F. S., <i>Los Angeles</i>		10
Crane, J. J., <i>Los Angeles</i>		10				Domann, A. H., <i>Orange</i>		16
Crane, W. R., <i>Los Angeles</i>		10				Donald, W. G., <i>Berkeley</i>		1
Crane, W. W., <i>Oakland</i>		1				Donelan, James P., <i>Los Angeles</i>		10
Crane, H. R., <i>Los Angeles</i>		10				Donohoe, W. D., <i>Los Angeles</i>		10
Craven, L. L., <i>Glendale</i>		10				Donohoe, E. C., <i>Glendale</i>		10
Craviotto, J. V., <i>Stockton</i>		24				Donovan, M., <i>San Francisco</i>		23
Crawford, J. W., <i>San Francisco</i>		23				Dooley, J. B., <i>Compton</i>		10
Crawford, W. W., <i>San Diego</i>		22				Doran, A. V., <i>Vallejo</i>		32
Crawshaw, J. A., <i>Hanford</i>		8				Dorius, G. R., <i>Oakland</i>		1
Crease, F. J., <i>Bakersfield</i>		16				Dormody, H. F., <i>Monterey</i>		14
Crease, H. G., <i>Bakersfield</i>		7				Dormody, H. L., <i>Monterey</i>		14
Cress, W. W., <i>Sacramento</i>		19				Dorr, W. R., <i>Arlington</i>		18
Crew, D. A., <i>San Luis Obispo</i>		25				Dostal, R. J., <i>Santa Monica</i>		10
Criley, C. H., <i>Los Angeles</i>		10				Dougall, J. P., <i>Los Angeles</i>		10
Crisp, N. J., <i>Benicia</i>		32				Dougan, S., <i>San Jose</i>		28
Crispin, E. L., <i>Los Angeles</i>		10				* Dougherty, E. E., <i>Los Angeles</i>		10
Crockett, H. C., <i>Hayward</i>		1				Dougherty, J. A., <i>Oakland</i>		1
Croft, L. E., <i>Ocean Park</i>		10				Dougherty, P. S., <i>Los Angeles</i>		10
Cronan, L. A., <i>Davis</i>		38				Doughty, J. F., <i>Tracy</i>		24
Cronemiller, R. E., <i>Exeter</i>		36				Douglass, G. H., <i>Los Angeles</i>		10
Crooks, S. A., <i>Loma Linda</i>		21				Douglass, P., <i>San Francisco</i>		23
Crosby, D., <i>Oakland</i>		1				Dow, J. N., <i>Los Angeles</i>		10
Cross, W. W., <i>Oakland</i>		1				Dowd, R. E., <i>San Bernardino</i>		21
Crossan, J. W., <i>Los Angeles</i>		10				Dowling, S. W., <i>Santa Cruz</i>		29
Crossen, A. S., <i>Weimar</i>		17				Downing, S. R., <i>Oakland</i>		1
Crow, L. B., <i>San Francisco</i>		23				Downs, A. J., <i>Los Angeles</i>		10
Crowe, H. E., <i>Los Angeles</i>		10				Downs, L., <i>Hollywood</i>		1
Crowe, J. A., <i>San Francisco</i>		23				Doyle, G. P., <i>Berkeley</i>		10
Crowl, V. C., <i>Huntington Park</i>		27				Doyle, J. B., <i>Los Angeles</i>		10
Crowley, E., <i>Santa Maria</i>		27				Doyle, J. C., <i>Los Angeles</i>		10
Crozler, H. C., <i>Los Angeles</i>		10				Doyle, J. J. L., <i>Chico</i>		2
Cruikshank, G. H., <i>San Diego</i>		22				Doyle, O. B., <i>Fresno</i>		4
Crum, H. C., <i>Alameda</i>		1				Dozier, D. F., <i>Sacramento</i>		19
Crum, R. A., <i>Oakland</i>		1				Dozier, E., <i>Redding</i>		30
Crusan, R. E., <i>Monrovia</i>		10				Dozier, E. G., <i>Pacoima</i>		10
Cryst, J. H., <i>Los Angeles</i>		10				Dozier, L., <i>Stockton</i>		24
Cullen, B. R., <i>Long Beach</i>		10				Dozier, T. J., <i>Antioch</i>		3
Cummings, H., <i>Los Angeles</i>		10				Drace, C. G., <i>Ojai</i>		37
Cummings, J. C., <i>Glendale</i>		10				Dragoo, S. V., <i>Avenal</i>		8
Cummings, R. A., <i>Los Angeles</i>		10				Drake, D. D., <i>San Francisco</i>		23
Cummings, R. S., <i>Los Angeles</i>		10				Drake, J. C., <i>Kerman</i>		4
Cummins, F. A., <i>Los Angeles</i>		10				Drees, L. A., <i>San Francisco</i>		23
Cunco, J. C., <i>San Jose</i>		28				Drennan, P. G., <i>Oakland</i>		1
Cuneo, P. J., <i>Bakersfield</i>		7				Dresel, R. L., <i>San Francisco</i>		23
Cunnane, P. J., <i>Los Angeles</i>		10				Drucks, E. S., <i>Oakland</i>		1
Cunnane, T. B., <i>Los Angeles</i>		10				Drummond, T. A., <i>Randsburg</i>		21
Cunningham, R. L., <i>Los Angeles</i>		10				Dryden, F. M., <i>Pasadena</i>		10

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NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Dryer, D. S.,	Los Angeles.	10	Emge, L. A.,	San Francisco.	23	Felps, H. E.,	Riverside.	18
Dryer, R. G.,	Los Angeles.	10	Emmons, C. L.,	Ontario.	21	Felsenthal, L.,	Los Angeles.	10
Dryfoos, H. L.,	San Francisco.	23	Empey, L. W.,	Roseville.	17	Felt, F. R.,	Jubbulpore, C. P., India	22
Dudley, H. W.,	San Rafael.	11	Empie, W. M.,	San Pedro.	10	Fenton, W. W.,	San Bernardino.	21
Duffley, G. W.,	Sacramento.	19	Emrick, E. L.,	Los Angeles.	24	Ferguson, R. A.,	Los Angeles.	10
*Duffield, W.,	Los Angeles.	10	Ende, F. M.,	Hollywood.	10	Fernandez, M. L.,	Pinole.	3
Duggan, H.,	San Francisco.	23	Endres, W. J.,	Los Angeles.	10	Fernish, C. A.,	Santa Clara.	28
Dukes, C. A.,	Oakland.	1	Eneboe, J. B.,	San Diego.	22	Ferrier, P. A.,	Pasadena.	10
Dunbar, W. V.,	San Pedro.	10	Engel, E. E.,	San Bernardino.	21	Ferry, F. C.,	Los Angeles.	10
Duncan, J. A.,	Marysville.	39	Engelman, W. T.,	San Bernardino.	21	Fetter, E. M.,	San Diego.	22
Duncan, M. V.,	Lompoc.	27	Engle, H. M.,	San Francisco.	23	Fibush, A.,	San Francisco.	23
Duncan, R. A.,	Placentia.	16	English, C. F.,	Stockton.	24	Fiegel, F. X.,	San Bernardino.	21
Duncan, R. D.,	Los Angeles.	10	English, G. G.,	Hollywood.	10	Field, A. M.,	Patterson.	34
Duncan, W. C.,	Los Angeles.	10	Enloe, N. T.,	Chico.	2	Fiedler, R. L.,	San Francisco.	23
Dundas, R. C.,	Los Angeles.	10	Enos, J. B.,	Oakland.	1	Fielding, G. A.,	Brentwood Heights	10
Dunievitz, M.,	Auburn.	17	Enos, M. M.,	Oakland.	1	Fields, M.,	Los Angeles.	10
Dunklee, G. K.,	San Luis Obispo.	25	Epsteen, A.,	San Francisco.	23	Fieseler, W. R.,	Los Angeles.	10
Dunlap, A. K.,	Sacramento.	19	Epstein, A. I.,	Los Angeles.	10	Filipello, E. A.,	San Jose.	28
Dunlevy, G. R.,	Los Angeles.	10	Epstein, N. N.,	San Francisco.	23	Fillmore, J. R.,	Strathmore.	36
Dunlop, J.,	Pasadena.	10	Erkenbeck, J. W.,	San Diego.	22	Finan, A. P.,	Suisun.	32
Dunn, R. D.,	San Francisco.	23	Erlanger, V. J.,	San Diego.	22	Finch, W. C.,	Los Angeles.	10
Dunn, R. H.,	San Francisco.	23	Ernsberger, G. H.,	Covina.	10	Findlay, F. M.,	Los Angeles.	27
Dunne, N. P.,	Oakland.	1	Escamilla, R. F.,	San Francisco.	23	Findlay, H. V.,	Santa Barbara.	27
Dupulich, L. R.,	Oakland.	1	Eshman, L. A.,	Los Angeles.	10	Findley, H. P.,	El Centro.	6
Durgin, R. M.,	Berkeley.	1	Eshoo, D.,	South Pasadena.	10	Fine, I. A.,	Los Angeles.	10
Durr, S. A.,	San Diego.	22	Esnard, R. P.,	Los Angeles.	10	Fine, M.,	San Francisco.	23
Dutcher, W.,	Los Angeles.	10	Esslinger, P. H.,	San Juan Capistrano.	16	Finkelberg, I. L.,	San Bernardino.	21
Dutton, M. L.,	San Francisco.	23	Etter, O. R.,	Oakland.	1	Finnerty, E. J.,	Sonoma.	33
Duvall, E. M.,	Long Beach.	10	Eusden, R. B.,	Long Beach.	10	Finsand, V.,	San Francisco.	23
Dye, W. G.,	Los Angeles.	10	Evans, H. R.,	Kernville.	7	Firestone, F.,	San Francisco.	23
Dyke, L. H.,	Oakland.	1	Evans, J. H.,	Highland.	21	Firor, M. P.,	Los Angeles.	10
Dykes, H. R.,	Taft.	7	Evans, L. M.,	Pasadena.	10	Fischer, S. S.,	Oakland.	1
Dyment, B. S.,	Stanford University.	28	Evans, N. G.,	S. Pasadena.	10	Fish, E. S.,	Beverly Hills.	10
Dysart, B. R.,	Pasadena.	10	Evans, R. D.,	Santa Barbara.	10	Fish, L. W.,	Los Angeles.	10
— E —			Evans, V. L.,	Aurora, Illinois.	25	Fishbaugh, E. C.,	Los Angeles.	10
Eager, B. F.,	San Diego.	22	Eveleth, R. H.,	Roseville.	17	Fishbon, H. M.,	San Francisco.	23
Eakin, M. A.,	Fresno.	4	Everingham, S.,	Oakland.	1	Fisher, A. L.,	San Francisco.	23
Earel, F.,	Santa Ana.	16	Everman, C. C.,	San Quentin.	11	Fisher, C.,	Los Angeles.	10
Earl, H. D.,	San Pedro.	10	Every, H. M.,	Petaluma.	33	*Fisher, C. A.,	Los Angeles.	10
Earle, L. M.,	Los Angeles.	10	EWENS, F.,	Beverly Hills.	10	Fisher, R. E.,	Pomona.	10
Early, C. E.,	Los Angeles.	10	Ewer, E. N.,	Oakland.	1	Fisher, R. H.,	Oakland.	1
Earwood, E. R.,	Los Angeles.	10	Ewer, J. N.,	Oakland.	1	Fisher, V. L.,	Long Beach.	10
Eastman, B. R.,	Pasadena.	10	Ewing, F. E.,	Oakland.	1	Fisher, W. L.,	Pomona.	10
Eastman, W. R.,	La Jolla.	22	Exelby, P. B.,	Los Angeles.	10	Fist, H. S.,	Los Angeles.	10
Easton, D. E. F.,	San Francisco.	23	Eymundson, K. S.,	San Francisco.	23	Fitzgerald, J. J.,	Richmond.	3
Eaton, H. D.,	Los Angeles.	10	— F —			Fitzgerald, W. W.,	Stockton.	24
Eaton, J. L.,	Berkeley.	1	Faber, H. K.,	San Francisco.	23	Fitzgibbon, C. C.,	Merced Falls.	13
Eaton, V. H.,	Santa Barbara.	27	Fabian, J. P.,	Chico.	2	Fitzpatrick, E. B.,	Martinez.	3
Eaves, J.,	Oakland.	1	Fagan, F. D.,	San Fernando.	10	Flamson, R. J.,	Los Angeles.	10
Eberhardt, G.,	Gonzales.	14	Fagan, R. H.,	Los Angeles.	10	Flatley, M.,	Weimar.	17
Ebert, C. E.,	Los Angeles.	10	Fagan, S. F.,	Los Angeles.	10	Fleisher, A. J.,	Berkeley.	1
Ebright, G. E.,	San Francisco.	23	Fagerstrom, D. P.,	San Jose.	23	Fleissner, C. M.,	Santa Rosa.	33
Eckerle, W. J.,	Wilmington.	10	Fairchild, A.,	Hollwood.	10	Fleming, E. W.,	Los Angeles.	10
Eckhardt, V.,	Los Angeles.	10	Fairchild, C. H.,	Woodland.	38	Fleming, H. W.,	San Francisco.	23
Eddy, I. H.,	Glendale.	10	Fairchild, F. R.,	Woodland.	22	Fleming, L. P.,	Sanger.	4
Eder, H. L.,	Santa Barbara.	27	Fairchild, L. H.,	Carlsbad.	10	Fleming, S.,	Eureka.	5
Eder, L. F.,	Santa Barbara.	27	Falconer, E. H.,	San Francisco.	23	Flesher, R. E.,	Gardena.	10
Edgerton, A. E.,	San Francisco.	23	Falconer, F. H.,	Los Angeles.	10	Fletcher, C. D.,	San Francisco.	23
Edler, W.,	Pasadena.	10	Falconer, R. A.,	Los Angeles.	10	Fletcher, E. G.,	Oakland.	1
Edmonds, F. W.,	Oakland.	1	Falk, C. C.,	Eureka.	5	Fletcher, H. A.,	San Francisco.	23
Edson, P. J.,	Pasadena.	10	Falk, C. C., Jr.,	Eureka.	5	Fletcher, R.,	San Francisco.	23
Edward, J. T.,	Pasadena.	10	Falk, C. L.,	Eureka.	5	Flewelling, L. M.,	Glendale.	10
Edwards, F. A.,	Los Angeles.	10	Falk, E. V.,	Modesto.	34	Flood, R. G.,	Sacramento.	19
Edwards, H. W.,	Los Angeles.	10	Falk, H.,	Visalia.	36	Flood, R. G.,	San Francisco.	23
Edwards, J. C.,	Berkeley.	1	Fallas, R. E.,	Los Angeles.	10	Floreth, O. P.,	Dixon.	32
Edwards, M. E.,	San Rafael.	11	Fanning, J. L.,	Sacramento.	10	Flower, K. C.,	Venice.	10
Edwards, W. M.,	San Francisco.	23	Fanson, E.,	Pasadena.	10	Fluhmann, C. F.,	San Francisco.	23
Egleston, E. F.,	San Francisco.	23	Faris, H. S.,	Riverside.	18	Flyer, H.,	Los Angeles.	10
Ehlers, E. C.,	Loma Linda.	21	Farman, G. F.,	Los Angeles.	10	Fogel, E. T.,	Los Angeles.	10
Ehlers, H.,	Fowler.	4	Farmer, J. L.,	San Diego.	22	Fogs, E. S.,	Wasco.	7
Ehrke, A. A.,	Compton.	10	Farmer, L. E.,	Folsom City.	19	Folkenberg, A. W.,	Los Angeles.	10
Eidenmuller, W. C., Jr.,	San Francisco.	23	Farnham, R. M.,	Glendale.	10	Folkens, F. H.,	Redlands.	21
Eisen, E. G.,	Los Angeles.	10	Farnsworth, T. K.,	Long Beach.	10	Folte, A. G.,	San Francisco.	23
Eiskamp, E. H.,	Watsonville.	23	Farr, W. H.,	Salinas.	14	Foord, A. G.,	Pasadena.	10
Eklund, O. E.,	San Francisco.	29	Farrage, J.,	Riverside.	18	Foot, C. G.,	San Diego.	22
Eldridge, S.,	Crockett.	3	Farrage, J.,	Santa Ana.	16	Foot, F. S.,	San Francisco.	23
Elkins, D. L.,	Long Beach.	10	Farrell, J. W.,	Los Angeles.	10	Forbes, H. J.,	Pasadena.	10
Ellefson, O. D.,	Hughson.	34	Farrell, L. W.,	Sacramento.	19	Forcade, W. P.,	San Francisco.	18
Elliot, A. H., Jr.,	Santa Barbara.	27	Farrington E. D.,	El Monte.	10	Ford, H. G.,	Richmond.	3
Elliot, A. L.,	Berkeley.	1	Farrow, E. J.,	San Diego.	22	Ford, R. A.,	Los Angeles.	10
Elliot, F. P.,	San Diego.	22	Fate, M. W.,	Los Angeles.	10	Fores, L.,	Oakland.	1
Elliot, H. M.,	Los Angeles.	10	Fate, W. A.,	Los Angeles.	10	Fornoff, H. S.,	Oakland.	1
Ellis, E. D.,	Altadena.	10	Fath, A.,	San Francisco.	23	Forsythe, J. S.,	San Bernardino.	21
Ellis, G.,	Berkeley.	1	Faulkner, E. C.,	Rio Vista.	32	Fortier, R. M.,	Salinas.	14
Ellis, H. O.,	Chico.	2	Faulkner, J. L.,	Red Bluff.	35	Fortson, G. R.,	Susanville.	9
Ellis, J. A.,	Alameda.	1	Faulkner, W. B., Jr.,	San Francisco.	23	Foshay, A. W.,	Oakland.	1
Ellis, L. T.,	Los Angeles.	10	Fay, J.,	San Francisco.	23	Foskett, H. S.,	Garfield, Wash.	37
Ellis, L. W.,	Los Angeles.	10	Fearn, J. R.,	Oakland.	1	Foster, A. H.,	Brawley.	6
Ellsworth, A. B.,	Long Beach.	10	Featon, W. M.,	Los Angeles.	10	Foster, C. A.,	Pacific Grove.	10
Ellwood, P. M.,	Oakland.	1	Feeley, M. A.,	San Francisco.	23	Foster, G. A.,	Grass Valley.	19
Eloesser, L.,	San Francisco.	23	Fegen, S.,	Los Angeles.	10	Foster, H. E.,	Berkeley.	1
Ely, L. W.,	San Francisco.	23	Fehlman, W. E.,	Santa Cruz.	29	Foster, J. G.,	Los Angeles.	10
Emerson, C. V.,	Los Angeles.	10	Fehrensen, G.,	Inglewood.	10	Foster, P. A.,	Los Angeles.	10
Emerson, M. L.,	Oakland.	1	Feinberg, H.,	San Francisco.	23	Foster, P. D.,	Los Angeles.	10
Emery, C. E.,	San Francisco.	23	Feingold, B. F.,	Los Angeles.	10	Fouch, F. L.,	San Francisco.	23
Emery, C. K.,	Los Angeles.	10	Felberbaum, W.,	Santa Paula.	37	Foulks, C. A.,	Long Beach.	10
			Feldman, C.,	Maywood.	10	Fountain, E. R.,	Merced.	13
			Feldman, J. F.,	Los Angeles.	10	Fowler, C. B.,	Oakland.	1
			Felger, L.,	Los Angeles.	10	Fowler, D. C.,	Mill Valley.	11
			Fellows, F. D.,	San Francisco.	23	Fowler, G. W. J.,	Santa Clara.	28
						Fowler, H. L.,	Los Angeles.	10
						Fox, C. M.,	San Diego.	22

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Fox, D. S., Berkeley.....		1	Garrett, F. H., Patton.....		21	Gloor, E. E., Watsonville.....		29
Fox, H. W., Tulare.....		36	Garrison, B. E., Riverside.....		18	Glyer, R. T., Mountain View.....		28
Fox, L. H., Bakersfield.....		7	Garrison, J. F., Inglewood.....		10	Gobar, F. H., Fullerton.....		16
Fox, W. F., El Centro.....		6	Garrison, O. H., Oakland.....		1	Gocher, T. E. P., Fairfax.....		11
Frame, P. W., Elk Grove.....		19	Garrison, W. P., Long Beach.....		10	Goddard, W. P., Mill Valley.....		11
Francis, R. T., Riverside.....		37	Garstang, D. B., Los Angeles.....		10	Godett, M. R., Los Angeles.....		10
Francis, R. K., Inglewood.....		10	Garth, W. L., San Diego.....		22	Godshall, L. D., Los Angeles.....		10
Francis, V. C., Long Beach.....		10	Garvin, C. L., Livingston.....		13	Godwin, D. E., Long Beach.....		10
Francis, W. V. C., Los Angeles.....		10	Gaspard, F. J., Los Angeles.....		10	Goeckerman, W. H., Los Angeles.....		10
Francouz, M. A., San Francisco.....		23	Gassman, F., Los Angeles.....		10	Goin, L. S., Los Angeles.....		10
Frandy, M. F., Oakland.....		1	Gasteiger, E. S., Los Angeles.....		10	Golden, J. H., San Francisco.....		23
Frank, J. A., Pismo Beach.....		25	Gates, C. Y., San Francisco.....		23	Goldberg, A. T., Fresno.....		4
Franklin, D. M., Los Angeles.....		10	Gates, F. K., El Monte.....		10	Goldberg, M. B., San Francisco.....		23
Franklin, E. A., Los Angeles.....		10	Gates, M. G., Ocean Park.....		10	Goldberg, P. H., Los Angeles.....		10
Franklin, W. S., Santa Barbara.....		27	Gates, M. J., Santa Cruz.....		29	Goldberg, S. S., Los Angeles.....		10
Fraser, H. E., San Francisco.....		23	Gates, R., Minot, N. D.....		27	Goldberg, V., Long Beach.....		10
Fraser, L. H., Richmond.....		3	*Gatliff, W. W., Butte City.....		38	*Golding, D. G., Santa Monica.....		23
Fraser, M. L., Los Angeles.....		10	Gattuccio, B., San Jose.....		28	Goldman, L., San Francisco.....		10
Frawley, J. M., Fresno.....		4	Gaulden, C. L., Los Angeles.....		10	Goldman, T. H., Los Angeles.....		10
Frederickson, H., Eldridge.....		33	Gauthier, A. E., San Francisco.....		23	Goldman, V. S., San Francisco.....		23
Freese, B. M., Los Angeles.....		10	Gay, H. M., Pasadena.....		10	Goldstein, J., Los Angeles.....		10
Fregeau, A. N., San Francisco.....		23	Gay, LeR. K., San Francisco.....		23	Goldstein, M. M., Fresno.....		4
Freibrun, J. L., Los Angeles.....		10	Geddes, M. A., Santa Ana.....		16	Goldwasser, M., Los Angeles.....		10
Freidell, H. F., Santa Barbara.....		27	Geen, R. S., Hollister.....		20	Golitzin, A., Hollywood.....		10
French, C. E., San Francisco.....		23	Gehrels, E., San Francisco.....		23	Gomes, J. J., Oakland.....		1
French, E. A., San Luis Obispo.....		25	Gehrels, F., San Mateo.....		23	Gompertz, K. R., Berkeley.....		1
French, J. R., Los Angeles.....		10	Geiger, J. C., San Francisco.....		26	Goodall, O. P., Bakersfield.....		7
Freudenthal, L., Gridley.....		2	Geisler, W. H., San Jose.....		28	Goodman, M., Stockton.....		24
Frey, B. A., Los Angeles.....		10	Geistweit, W. H., Jr., San Diego.....		22	Gorb, R., San Francisco.....		23
Frey, R. G., Red Bluff.....		35	Geith, C. R., Riverside.....		18	Gordon, G. O., Long Beach.....		10
Frey, W. C., San Francisco.....		23	Geiston, C. F., San Francisco.....		23	Gordon, K. W., Los Angeles.....		10
Freyermuth, O. G., San Francisco.....		23	Gentry, H. G., Redlands.....		21	Gordon, M. R., San Francisco.....		23
Freytag, C. F., Los Angeles.....		10	George, A. R., Loma Linda.....		21	Gorham, C. B., Monterey.....		14
Frick, D. J., Los Angeles.....		10	George, J. DeW., Hollywood.....		10	Gorrell, J. S., Los Angeles.....		10
Fricke, A. A., Los Angeles.....		10	George, J. M., San Francisco.....		23	Gotse, S. M., San Francisco.....		23
Friedberger, W., Stockton.....		24	George, L. H., Loma Linda.....		21	Gossage, H. S., Petaluma.....		33
Friedlander, R. D., San Francisco.....		23	George, W. A., Loma Linda.....		21	Gossard, J. E., Sierra Madre.....		10
Friedman, A., San Francisco.....		26	Gerisch, W. H., Los Angeles.....		10	Gotfredson, H. L., So. Pasadena.....		10
Friedman, J. C., Banning.....		18	Gerlach, F. C., San Jose.....		28	Gottbrath, N. J., Agnew.....		28
Friedman, M., Los Angeles.....		10	Gerlough, R. J., Menlo Park.....		26	Gottlieb, A. J., Los Angeles.....		10
Friesen, H. J., Glendale.....		10	Germann, A. C., Los Angeles.....		10	Gottschalk, A., San Francisco.....		23
Frish, A., Los Angeles.....		10	Gernand, H. C., Los Angeles.....		10	Gough, A. S., El Segundo.....		10
Fritschen, W., San Francisco.....		23	Gerrard, C. C., Redding.....		30	Gougnet, L. J., Sacramento.....		19
Frizzell, R. R., Pasadena.....		10	Gerstle, M. Jr., San Francisco.....		23	Gould, A. A., Los Angeles.....		10
Froehlich, D. E., Oakland.....		1	Geshelin, H. I., Los Angeles.....		10	Gould, N. B., Modesto.....		34
Frohmman, B. S., Los Angeles.....		10	Getze, G. W., Carlsbad.....		22	Gourley, I., Livermore.....		1
Frost, E., Stockton.....		24	Geyman, M. J., Santa Barbara.....		27	Gowan, C. H., Glendale.....		10
Frost, G. A., Oroville.....		9	Ghormley, V. G., Fresno.....		4	Graeser, H. B., Holtville.....		6
Frost, K. P., Los Angeles.....		10	Ghrist, D. G., Los Angeles.....		10	Graeser, J. B., Oakland.....		1
Frudenfeld, J. C., Inglewood.....		10	Ghrist, D. M., Glendale.....		10	Graham, H. B., San Francisco.....		23
Frug, J., Oakland.....		1	Ghrist, O. E., Glendale.....		10	Graham, H. K., San Diego.....		22
Fuller, H. L., San Diego.....		22	Giannini, A. H., Los Angeles.....		23	*Graham, J. A., Barstow.....		22
Fuller, M. B., Julian.....		22	Giberson, A. F., Watsonville.....		29	Graham, J. P., Los Angeles.....		10
Fueller, R. N., Tulare.....		36	Gibbons, H., III, Silver Lake.....		23	Graham, L., Newberry.....		21
Fulmer, C. C., San Francisco.....		23	Gibbons, H. W., Sacramento.....		19	Graham, R. E., Oakland.....		1
Fung, L., Sacramento.....		19	Gibbons, M. R., San Francisco.....		23	Graham, R. S., Sacramento.....		19
Furbush, C. G., Oakland.....		1	Gibbons, M. R., Jr., San Francisco.....		23	Granger, A. S., Los Angeles.....		10
Furlong, R. M., San Francisco.....		11	Gibbs, D. H., Los Angeles.....		10	Grant, B. E., Jr., Hollywood.....		10
Furness, G. B., Visalia.....		36	Gibbs, R. S., San Bernardino.....		21	Grant, J. F., Long Beach.....		10
Furstman, J. M., Monrovia.....		10	Gibbs, W. M., Glendale.....		10	Grant, R. E., San Francisco.....		23
Futch, C. E., Los Angeles.....		10	Gibson, A. L., Los Angeles.....		10	Gratiot, W. M., Monterey.....		14
- G -			Gibson, T. E., San Francisco.....		23	Grau, E. C., Niles.....		1
Gaffney, G. F., San Francisco.....		23	Gidley, D. S., Ontario.....		21	Graun, R. E., Los Gatos.....		28
Gafford, J. A., Huntington Park.....		10	Gidoll, S. H., San Francisco.....		23	Graves, C. A., Beverly Hills.....		10
Gage, A. E., Los Angeles.....		10	Gifford, M. A., Bakersfield.....		23	Graves, J. H., San Francisco.....		23
Gage, A. T., Redlands.....		21	Gilbert, J. S., Los Angeles.....		10	Graves, J. M., San Francisco.....		23
Gage, C. E., Los Angeles.....		10	Gilbert, N., Van Nuys.....		10	Graves, R. V., Fullerton.....		16
Gageby, L. H., Los Angeles.....		10	Gilbert, Q. O., Oakland.....		1	Gray, E., Los Angeles.....		10
Gagnon, A. L., San Diego.....		22	Gilbert, R., San Francisco.....		23	Gray, E. E., Marysville.....		39
Gailland, C. R., Los Angeles.....		10	Gilbert, W. H., Los Angeles.....		10	Gray, E. H., Woodland.....		38
Galbraith, A., Oakland.....		1	Gilcreest, E. L., San Francisco.....		23	Gray, G. A., San Jose.....		28
Galbraith, G. H., Long Beach.....		10	Giles, F. E., Los Angeles.....		10	Gray, H., San Francisco.....		23
Gale, V. V., Los Angeles.....		10	Gillfillan, H. M., San Francisco.....		23	Gray, J. P., San Francisco.....		23
Gallagher, H. F., Los Angeles.....		10	Gillkey, W. D., Long Beach.....		10	Gray, J. R., Carmel.....		14
Gallagher, V. J., Los Angeles.....		10	Gillespie, P. B., Santa Ana.....		16	Gray, P. A., Jr., Santa Barbara.....		27
Gallant, A. E., Los Angeles.....		10	Gillfiatt, W. H., Coalinga.....		4	Gray, R. M., Indio.....		18
Gallant, P. A., Huntington Park.....		10	Gillfhan, A. F., San Luis Obispo.....		25	Gray, R. N., Hartford, Conn.....		23
Gallegos, P. B., Stockton.....		24	Gillfiand, M. L., Los Angeles.....		10	Graybill, M. B., Escondido.....		22
Galligan, C. A., Monterey.....		14	Gilliland, R. C., Huntington Park.....		10	Grayman, H. M., Dos Palos.....		13
Galloway, J., San Francisco.....		23	Gillis, J. D., Los Angeles.....		10	Green, A. S., San Francisco.....		23
Gamette, D. L., Los Angeles.....		10	Gillis, J. P., Los Angeles.....		10	Green, B., Jr., Riverside.....		18
Ganoc, C. V., Los Angeles.....		10	Gilman, A. A., San Francisco.....		23	Green, D. M., Los Angeles.....		10
Gans, C. C., Redwood City.....		26	Gilman, P. K., San Francisco.....		23	Green, H. R., Palo Alto.....		28
Gans, C. H., Long Beach.....		10	Gilman, P. J., Jr., San Francisco.....		23	Green, J., Los Angeles.....		10
Gant, H. R., Modesto.....		34	Gingold, B., Los Angeles.....		10	Green, J. W., Vallejo.....		32
Garcia, L. C., San Francisco.....		23	Ginsburg, H. M., Fresno.....		4	Green, L. D., San Francisco.....		23
Gardner, C. S., Oakland.....		1	Ginsburg, S. S., Visalia.....		36	Green, M. I., San Francisco.....		23
Gardner, F. M., San Bernardino.....		21	Girard, F. R., San Francisco.....		23	Green, M. M., Stockton.....		24
Gardner, F. W., Loma Linda.....		21	Girdlestone, C. W., Riverside.....		18	Green, R. C., Oak Park, Illinois.....		16
Gardner, H. L., San Francisco.....		23	Glus, E. A., San Francisco.....		23	Greenbaum, G. B., Los Angeles.....		10
Gardner, K. D., San Francisco.....		23	Gluscock, F. L., Los Angeles.....		10	Greenbaum, I. H., Los Angeles.....		10
Gardner, W. E., Riverside.....		18	Glaser, M. A., Los Angeles.....		10	Greenko, C. G., Los Angeles.....		10
Gardnrcr, W. M., Los Angeles.....		23	Glass, K. W., Venice.....		10	Greenman, R. A., Stockton.....		24
Garfinkle, F. E., San Francisco.....		23	Glass, S. J., Los Angeles.....		10	Greenway, H. H., Los Angeles.....		10
Garland, L. H., San Francisco.....		23	Glassman, S. C., Los Angeles.....		10	Greenwood, C. F., Oakland.....		1
Garner, G. W., Taft.....		7	Gleason, A. L., Oakland.....		1	Greenwood, E. N., San Francisco.....		23
Garnett, A. S., San Bernardino.....		21	Giceten, S. D., Monrovia.....		10	Greer, E. D., Oakland.....		1
			Glenn, LaV. P., Folsom.....		19	Gregg, F. C., Calexico.....		6
			Glenn, R. A., Oakland.....		1	Gregg, H. J., Calexico.....		6
			Glenn, T. H., Los Angeles.....		10	Gregory, C. A., Sanitarium.....		15
			Gldden, R. Y., Jr., Los Angeles.....		10	Gregory, F. S., Redwood City.....		26
			Gillebe, P. A., San Francisco.....		23	Gregory, H. L., Stockton.....		24

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Gregory, W. A.,	Oakland	1	Hamilton, P. L.,	Chico	2	Hawkins, H. M.,	Taft	10
Grey, C. A.,	Burbank	10	Hamilton, P. M.,	Alhambra	10	Hawkins, J. O.,	San Rafael	11
Griess, R. O.,	Salinas	14	Hamilton, R. L.,	Marysville	39	Hawkins, L. P.,	Los Angeles	10
Griffin, W. L.,	Los Angeles	10	Hamlin, O. D.,	Oakland	1	Haworth, M. W.,	Sacramento	19
Griffith, A. H.,	Oakland	1	Hamlin, R. E.,	Santa Rosa	33	Haworth, W. L.,	Los Angeles	10
Griggs, D. E.,	Los Angeles	10	Hammack, R. W.,	Los Angeles	10	Hay, E. O.,	Los Angeles	10
Grimmer, E. M.,	Irvington	1	Hammans, E. B.,	Los Angeles	10	Hayes, C. M.,	Los Angeles	10
Griner, E. C.,	Stockton	24	Hand, F. B.,	San Francisco	23	Hayes, E. W.,	Monrovia	10
Grishaw, W. H.,	Los Angeles	10	Hand, H. M.,	San Francisco	23	Haygood, A. G.,	Downey	10
Groat, M. J.,	Los Angeles	10	Hand, L. J.,	San Francisco	23	Hayhurst, D. E.,	Ontario	21
Groff, S. H.,	Los Angeles	10	Hanford, F. W.,	Los Angeles	10	Hayhurst, J. S.,	Redlands	21
Grogan, R. E.,	Los Angeles	10	Hankins, F. D.,	Riverside	18	Haynes, F. W.,	Los Angeles	10
Gronhovd, G. O.,	Santa Paula	37	Hankins, J. W.,	Azusa	10	Haynes, J. R.,	Los Angeles	10
Groper, M. J.,	San Francisco	23	Hanley, B. J.,	Los Angeles	10	Hays, M. S.,	San Francisco	23
Gross, H. G.,	Eureka	5	Hanlon, E. R.,	Los Angeles	10	Hayton, C. H.,	Los Angeles	10
Grosse, A. B.,	San Francisco	23	Hanlon, E. W.,	San Francisco	23	Hazel, J. K.,	San Francisco	23
Groves, R. L.,	San Francisco	23	Hanlon, H. H.,	Los Angeles	10	Hazeltine, M. E.,	San Rafael	11
Grow, L. W.,	San Diego	22	Hanna, C. M.,	McArthur	30	* Heald, A. H.,	San Francisco	26
Gruber, F. G.,	Santa Monica	16	Hannah, W.,	Long Beach	10	Heald, E. S.,	Berkeley	1
Grundy, G. M.,	Newport Beach	10	Hansen, A. M.,	Los Angeles	10	Heard, W. R.,	Pasadena	10
Gudel, A. E.,	Beverly Hills	10	Hansen, O. J.,	Redding	30	Hearn, T. M., Jr.,	Los Angeles	10
Guenther, L. P.,	Los Angeles	10	Hanson, S.,	Stockton	24	Hebert, A. W.,	San Francisco	23
Guersey, P. F.,	Los Angeles	10	Hanten, J. G.,	San Francisco	23	Hector, R.,	Berkeley	1
Guerra, A. L.,	Alameda	1	Hanze, H. S.,	Solvang	27	Hedberg, C. C.,	San Francisco	23
Guidinger, W. E.,	San Pedro	10	Hanzlik, P. J.,	San Francisco	26	Heddens, V. O.,	Pasadena	10
Guido, F. R.,	Visalia	36	Happ, W. M.,	Los Angeles	10	Hedges, L. A.,	Richmond	3
Guinan, E. R.,	Richmond	3	Hara, H. J.,	Los Angeles	10	Heegler, F. D.,	Napa	15
Gumbiner, A. A.,	Los Angeles	10	Hara, M. F.,	Los Angeles	10	Heffelfinger, M. A.,	Los Angeles	10
Gummess, K. C.,	Los Angeles	10	Harada, M. A.,	Sacramento	19	Heffernan, W. T.,	Calverico	6
Gummig, E. A.,	Pasadena	10	Harbaugh, O. S.,	San Diego	22	Heidenreich, H. H.,	Los Angeles	10
Gumpert, M. W.,	Los Angeles	10	Harbaugh, R. W.,	San Francisco	23	Heidenreich, W. M.,	Arcadia	10
Gunderson, H. J.,	Los Angeles	10	Harbert, E.,	Stockton	24	Heiges, L. E.,	Lompoc	27
Gundrum, F. F.,	Sacramento	19	Hardeman, V. V.,	San Francisco	23	Hein, G. E.,	San Francisco	23
Gundrum, L. K.,	Los Angeles	10	Harder, W. R.,	Los Gatos	28	Heinatz, M. A.,	Oakland	1
Gundrum, W. H.,	Owensmouth	10	Harding, G. F.,	Santa Monica	10	Heinz, R.,	Yountville	1
Gundry, F. J.,	Bakersfield	7	Harding, H. W.,	Oakland	1	Heinzman, W. H.,	San Francisco	23
Gunn, F. G.,	Kelseyville	15	Harding, L. W.,	Los Angeles	10	Heissig, I.,	Los Angeles	10
Gunter, M. L.,	Los Angeles	10	Harding, M. C.,	San Diego	22	Held, F.,	Colton	16
Gurdin, M. M.,	Los Angeles	10	Harding, T. E. W.,	Los Angeles	10	Helsley, G. F.,	San Francisco	23
Gustafson, A. W.,	Gustine	13	Hardy, B. W.,	Huntington Beach	16	Helstrom, G. L.,	Fontana	21
Gustafson, R. K.,	Pasadena	10	* Hare, G. A.,	Fresno	4	* Hemken, L.,	Los Angeles	10
Guttman, P. H.,	Sacramento	19	Hare, H. P.,	Los Angeles	10	Hemminger, G. W.,	Biggs	2
- H -			Hare, M. M.,	Glendale	10	Hench, J. M.,	Stockton	24
Haag, E. C.,	Sacramento	19	Hare, R. A.,	Santa Barbara	27	Henderson, A. M.,	Sacramento	19
Haas, S. L.,	San Francisco	23	Harmon, E. D.,	San Francisco	23	Henderson, E. W.,	Alameda	1
Haber, W. J.,	San Francisco	23	Harmon, R. J. P.,	Richmond	3	Henderson, H. E.,	Santa Barbara	27
Hablutzel, C. E.,	San Jose	28	Harmon, T. G.,	San Francisco	23	Henderson, H. G.,	San Francisco	23
Haddon, M. B.,	Oakland	1	Harner, C. E.,	Long Beach	10	Henderson, J. G.,	San Francisco	23
Haddow, N. W. A.,	Hollywood	10	Harner, H. R.,	Los Angeles	10	Henderson, R. G.,	Long Beach	10
Hadley, C. M.,	San Bernardino	21	Harrington, D. O.,	San Francisco	23	Henderson, W. R.,	Long Beach	10
Haenszel, A. L.,	San Bernardino	21	Harrington, E. R.,	San Francisco	23	Hendricks, F. R.,	Ventura	37
Hagedorn, E. F.,	Modesto	34	Harrington, J. T.,	Santa Cruz	29	Hendrickson, H. S.,	Los Angeles	10
Hagen, H.,	San Luis Obispo	25	Harr, R. V.,	Eldridge	33	Henke, G. B.,	Ontario	21
Hager, B. H.,	Los Angeles	10	Harris, E. L.,	Oakland	1	Henning, B. H.,	San Francisco	23
Hagerty, T. W.,	Camarillo	24	Harris, F. I.,	San Francisco	23	Henninger, L. L. R.,	Pasadena	10
Hahn, L. W.,	Berkeley	1	Harris, H. I.,	Los Angeles	10	Henrich A. G.,	Los Angeles	10
Haig, T. R.,	Sacramento	19	Harris, J. B.,	Sacramento	19	Henry, A. W.,	San Leandro	1
Haight, L. M.,	Stockton	24	Harris, J. M.,	Los Angeles	10	Henry, J. R.,	Oakland	10
Haim, A.,	San Francisco	23	Harris, M. S.,	Los Angeles	10	Henry, L. L.,	Altadena	1
Haines, C. L.,	Altadena	10	Harris, M. W.,	Ross	11	Henry, M. G.,	Los Angeles	10
Haines, W. H.,	Etna	31	Harris, R. C.,	Santa Ana	16	Hensel, G. C.,	San Francisco	23
Haining, R. B.,	Glendale	10	Harris, R. E.,	San Francisco	23	Henster, H. N.,	San Anselmo	11
Hainsworth, E. L.,	Ventura	37	Harris, R. H.,	Battle Creek, Mich.	10	Hepplewhite, J. G.,	Chico	2
Halburg, C. T.,	Glendale	10	Harris, W. A.,	Santa Ana	16	Herman, B. S.,	San Francisco	23
Haldean, K. O.,	San Francisco	23	Harrison, E.,	Los Angeles	10	Herman, H. E.,	Corona	18
Hale, C. W.,	Pomona	10	* Harrison, F.,	Gridley	2	Heron, I. C.,	San Francisco	23
Hale, N. G.,	Sacramento	19	Harrison, W. H.,	San Francisco	23	Herrick, A. B., Jr.,	Santa Rosa	33
Haley, P. S.,	San Jose	28	Harsh, G. F.,	San Diego	22	Herrick, F. L.,	Livermore	1
Hall, A. F., Jr.,	Los Angeles	10	Hart, A. C.,	Sacramento	19	Herring, J. B.,	San Francisco	23
Hall, C.,	Oakland	1	Hart, C. D.,	San Francisco	23	Herrington, E. L.,	San Francisco	23
Hall, C.,	Los Angeles	10	Hart, D. E.,	Oakland	1	Hersch, H. L.,	Los Angeles	10
Hall, C. C.,	Oakland	1	Hart, M. E.,	San Francisco	26	Hershberg, D.,	Los Angeles	10
Hall, E. H.,	Vernon	10	Hart, V. W.,	Yreka	31	Hershberger, L.,	Los Angeles	10
Hall, E. M.,	Los Angeles	10	Hart, W. E.,	Glendale	10	Hershey, C. J.,	Los Angeles	10
Hall, G. J.,	Sacramento	19	Hart, W. E.,	Oakland	1	Hershman, F.,	Los Angeles	10
Hall, G. P.,	San Jose	28	Harter, T. H.,	Pasadena	10	Hertzog, F. C.,	Long Beach	10
Hall, G. S.,	Los Angeles	10	Hartman, G. J.,	Pasadena	10	Herziko, S. S.,	Los Angeles	10
Hall, H. A.,	Redlands	10	Hartman, G. W.,	San Francisco	23	Herzog, G. K.,	San Francisco	23
Hall, L. L.,	Montebello	10	Hartman, H.,	Modesto	11	Hessel, V. E.,	Los Angeles	10
Hall, R. C.,	San Diego	22	Hartman, M. M.,	San Francisco	23	Heuler, L.,	Fellows	7
Hall, T. G.,	San Francisco	23	Hartman, R. B.,	Mill Valley	11	Heuschele, W. H.,	San Jose	28
Halley, E. C.,	Sanger	4	Hartwell, R. W.,	Beaumont	18	Hewitt, D.,	Long Beach	10
Halloran, C. R.,	Los Angeles	10	Hartwig, L. G.,	Los Angeles	10	Hewitt, G. W.,	Los Angeles	10
Halsey, W. H.,	San Diego	22	Haruff, J. J.,	Hollister	20	Heylmun, H. H.,	Long Beach	10
Halverson, W. L.,	Pasadena	10	Harvey, J. E.,	Pasadena	10	Hiatt, R. S.,	Modesto	34
Ham, G. H.,	Culver City	10	Harvey, R. J.,	Anaheim	16	Hibben, J. S.,	Pasadena	10
Haman, J. O.,	San Francisco	23	Harwood, C. M.,	Santa Ana	16	Hickey, N. G.,	Walnut Park	10
Hambleton, H. G.,	Los Angeles	10	Harwood, D. A.,	Santa Ana	16	Hicks, A. M.,	San Francisco	23
Hambleton, M. P.,	Fontana	21	Hashiba, G. K.,	Fresno	4	* Hicks, J. R.,	Tularc	36
Hambo, C. C.,	Santa Monica	18	Haskell, H. A.,	Windsor	33	* Hieronymus, A.,	Alameda	1
Hamer, C.,	Glendale	10	Haskell, P. F.,	Artesia	10	Higbee, D. R.,	San Diego	22
Hamilton, E. M.,	Los Angeles	10	Hastings, H.,	Los Angeles	10	Higgs, D. W. P.,	Chula Vista	22
Hamilton, G. V.,	Santa Barbara	27	Hastings, S. W.,	Monterey	14	Hill, A. L.,	Los Angeles	10
Hamilton, H. P.,	Santa Monica	10	Hastreiter, R. F.,	Los Angeles	10	Hill, E. J.,	Eureka	5
Hamilton, J. K., Jr.,	Alameda	1	Hathfield, H. L.,	Pasadena	1	Hill, E. W.,	San Andreas	24
Hamilton, J. R.,	Los Angeles	10	Havemann, M. S.,	Alameda	1	Hill, H. A.,	San Francisco	23
Hamilton, L. M.,	Oakland	1	Havenhill, A. D.,	Tombales	23	Hill, H. G.,	Redlands	21
			Hawes, R. E.,	Huntington Beach	16	Hill, H. P.,	San Francisco	23
			Hawk, C. L.,	Los Angeles	10	Hill, J. C.,	Palm Springs	18
			Hawkins, C. L.,	Taft	7	Hill, L. R.,	Long Beach	10
			Hawkins, G. A.,	Reedley	4	Hill, M. R.,	Los Angeles	10
			Hawkins, G. G.,	Madera	4	Hill, R. B.,	Los Angeles	10

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Hill, R. C., Exeter.....		36	Houck, G. H., Los Angeles.....		10	Irwin, J. C., Los Angeles.....		10
Hill, T. P., Lakeport.....		12	Hough, R. C., San Diego.....		22	Isaac, J. P., Glendale.....		10
Hill, W. B., Long Beach.....		10	Houghton, A. D., San Fernando.....		10	Isardi, M., San Francisco.....		23
Hiller, A. W., Long Beach.....		10	Houloose, J., Long Beach.....		10	Isard, M. C., Sacramento.....		19
Hilliard, C. G., Redlands.....		21	House, L. C., El Centro.....		6	Ito, P. K., Los Angeles.....		10
Hills, C. B., Berkeley.....		1	Houseworth, A. L., Los Angeles.....		10	Ivey, E. D., Oakland.....		1
Hillyard, L. V., Los Angeles.....		10	Housman, N. S., San Francisco.....		23			
Hillyer, L., Los Banos.....		13	Houston, A. J., San Francisco.....		23			
Hilton, J. J., Los Angeles.....		10	Houzvicka, O. A., San Diego.....		22			
Hines, D. C., Palo Alto.....		28	Hovde, A. G., Hollywood.....		10			
Hines, L. W., Santa Rosa.....		33	Howard, B. F., Sacramento.....		19			
Hinman, F., San Francisco.....		23	Howard, C. E., San Diego.....		22			
Hippach, R. M., Los Angeles.....		10	Howard, G. R., Bell.....		10			
Hirsch, D. L., Grass Valley.....		17	Howard, N. J., San Francisco.....		23			
Hirschfeld, M. H., San Francisco.....		23	Howe, R. D., Redwood City.....		26	Jackson, E. A., Atwater.....		13
Hirschfeld, S., Los Angeles.....		10	Howell, A. J., Berkeley.....		1	Jackson, J. A., La Jolla.....		10
Hiscox, E. J., Loma Linda.....		21	Howell, E. H., San Francisco.....		23	Jackson, J. E., Los Angeles.....		10
Hitchcock, H. H., Oakland.....		1	Howitt, H. O., San Rafael.....		11	Jackson, L. H., W. Los Angeles.....		10
Hixson, W. C., Jr., Beverly Hills.....		10	Howson, C. R., Los Angeles.....		10	Jacob, H. H., Long Beach.....		10
Hoag, C. L., San Francisco.....		23	Hoyt, H. S., Pacific Grove.....		14	Jacobs, A. M., San Francisco.....		23
Hoag, H. J., San Jose.....		28	Hoyt, W. F., Berkeley.....		1	Jacobs, F. E., San Diego.....		22
Hoagland, H., Palm Springs.....		18	Hromadka, A. B., Santa Monica.....		10	Jacobs, J., Los Angeles.....		10
Hobby, W. C., San Francisco.....		23	Hubbard, C. D., Huntington Park.....		10	Jacobs, L. C., San Francisco.....		23
Hodgdon, F. W., Jr., Pasadena.....		10	Hubbart, R. H., San Diego.....		22	Jacobs, L. G., San Francisco.....		23
Hodges, W. A., La Vina.....		10	* Hubble, J. E., Pomona.....		10	Jacobs, S. N., San Francisco.....		23
Hodgin, R. I., Upland.....		21	Hubert, C. I., Los Angeles.....		10	Jacobson, H. A., Fresno.....		4
Hodgins, F. W., Oakland.....		1	Huenergardt, A. G., Los Angeles.....		10	Jacobson, H. P., Los Angeles.....		10
Hodgkin, P., El Centro.....		6	Huenergardt, H. A., Berkeley.....		1	Jacobson, P. N., Oakland.....		1
Hoefler, A. G., San Diego.....		22	Huff, G. D., San Diego.....		22	Jacobus, L. R., Berkeley.....		1
Hoffman, A. M., Los Angeles.....		10	Huff, L. J., Los Angeles.....		10	Jackic, R. F., San Francisco.....		23
Hoffman, E. F., Los Angeles.....		10	Huffman, H. G., Santa Ana.....		16	James, C. A., Fresno.....		4
Hoffman, H. V., San Francisco.....		23	Huffman, L. D., Los Angeles.....		10	James, C. M., Beverly Hills.....		10
Hoffman, L. H., San Francisco.....		23	Huggins, W. L., Los Angeles.....		10	James, C. S., Los Angeles.....		10
Hoffman, P. B., Marysville.....		39	Hughes, E. G., Long Beach.....		10	James, L., Fresno.....		4
Hoffman, P. E., San Francisco.....		23	Hughes, R. E., Los Angeles.....		10	James, M., San Francisco.....		23
Hoffman, R. O., San Diego.....		22	Hughes, S. E., Los Angeles.....		10	James, R. J., Los Angeles.....		10
Hogan, M. J., San Diego.....		22	Hull, E. H., San Bernardino.....		21	James, V. M., Hollywood.....		10
Hogg, R. L., Saratoga.....		28	Hull, J. P., Stockton.....		24	Jameson, P. V., Huntington Park.....		10
Hohanshelt, A. S., Olive View.....		10	Hull, L. C., Hollister.....		20	Jankay, L., Santa Barbara.....		10
Hohl, E. M., Los Angeles.....		10	Hull, R. L., Hollister.....		20	Jardini, A., Los Angeles.....		10
Hohnstein, F. I., Oakland.....		1	Humber, J. D., San Francisco.....		23	Jeancon, E. C., Los Angeles.....		10
Hoke, P. I., Los Angeles.....		10	Hummel, E. M., Talmage.....		17	Jeffrey, D. E., Oakland.....		1
Holcomb, W. F., Oakland.....		1	Hummelt, B. W., Nevada City.....		1	Jeffs, M. D. W., Los Angeles.....		10
Holder, H. G., San Diego.....		22	Humphrey, W. H., Oakland.....		1	Jellick, J. J., Los Angeles.....		10
Holeman, G. S., Centerville.....		1	Humphreys, J. M., Sanger.....		4	Jelte, S. A., Oakland.....		1
Holladay, F. S., Los Angeles.....		10	Hunnicut, C. C., Los Angeles.....		10	Jenkins, B. E., Oakland.....		1
Hollenbeck, A. E., Eagle Rock.....		10	Hunnicut, L. G., Pasadena.....		10	Jenkins, H. L., Arcata.....		5
Holleran, G. C., Brawley.....		6	Hunsberger, H. S., San Francisco.....		23	Jenkins, K. B., Oakland.....		1
Holleran, J. F., Los Angeles.....		10	Hund, H. O., San Rafael.....		11	Jenkins, M. E., Peiping, China.....		23
Holleran, W. M., Los Angeles.....		10	Hunt, R. A., Riverdale.....		4	Jenkins, R. B., Los Angeles.....		10
Holley, W. W., Inglewood.....		10	Hunt, V. C., Los Angeles.....		10	Jenney, E. R., Los Angeles.....		10
Holliger, C. D., Stockton.....		24	Hunt, W. A., Fresno.....		4	Jcney, W. C., Vacaville.....		32
Hollingsworth, J. B., Woodland.....		38	Hunt, W. R., Santa Barbara.....		27	Jennison, J. E., San Diego.....		22
Hollingsworth, L. D., Los Angeles.....		10	Hunter, P. M., Pebble Beach.....		14	Jensen, O. B., Livermore.....		1
Hollingsworth, M. W., Santa Ana.....		16	Hunter, T. V., Hollywood.....		10	Jesberg, S., Los Angeles.....		10
Hollingsworth, P., Jamul.....		22	Hunter, W. E., South Gate.....		10	Jetton, J. A., Fallbrook.....		22
Hollombe, B. S., Los Angeles.....		10	Hunter, W. E., Los Angeles.....		10	Jewel, R. T., Los Angeles.....		10
Holm, E., Eureka.....		5	Huntley, A. C., Point Arena.....		12	Jewett, R. A., Los Angeles.....		10
Holman, E. F., San Francisco.....		23	Huntington, B. R., Los Angeles.....		10	Jimerson, J. R., Long Beach.....		10
Holman, W. F., Los Angeles.....		10	Huntington, H. A., Los Angeles.....		10	Johnson, A. L., Vallejo.....		32
Holmer, V. C., San Francisco.....		23	Hurd, A. H., Los Angeles.....		10	Johnson, C. A., Los Angeles.....		10
Holmes, A. J., Pasadena.....		10	Hurwitz, S. J., San Francisco.....		23	Johnson, C. E., Long Beach.....		10
Holmes, F., Beverly Hills.....		10	Hurwitz, S., San Francisco.....		23	Johnson, C. F., Oakland.....		1
Holmes, O. M., San Mateo.....		26	Hurwitz, S. H., San Francisco.....		23	Johnson, C. G., Long Beach.....		10
Holt, C. Z., Los Angeles.....		10	Husband, R. D., Modesto.....		34	Johnson, C. M., San Francisco.....		23
Holt, R. A., Jr., Los Angeles.....		10	Huston, J. M., Burlingame.....		26	Johnson, C. R., Whittier.....		10
Holzman, A. J., Santa Barbara.....		27	Hutchings, R. K., San Francisco.....		23	Johnson, D. D., Grass Valley.....		17
Holzman, R. R., Los Angeles.....		10	Hutchinson, W. W., Los Angeles.....		10	Johnson, E. D., Alhambra.....		10
Hombach, F. J., Santa Barbara.....		27	Hutchison, C. W., Los Angeles.....		10	Johnson, E. E., Palo Alto.....		28
Homer, R. W., Ventura.....		37	Hyde, R. D., Beverly Hills.....		10	Johnson, E. H., Los Angeles.....		10
Homman, G. L., Los Angeles.....		10	Hyland, C. M., Los Angeles.....		10	Johnson, F. T., Monrovia.....		10
Homme, O. H., Los Angeles.....		10	Hyman, E., Los Angeles.....		10	Johnson, G. M., Los Angeles.....		10
Honaker, G. T., San Leandro.....		1	Hyman, S., Los Altos.....		23	Johnson, G. S., San Francisco.....		23
Honor, H. C., Cotati.....		33				Johnson, H. H., San Francisco.....		23
Honor, V. O., Cotati.....		33				Johnson, H. M., Pasadena.....		19
Hoobler, H. R., Oakland.....		1				Johnson, H. R., Sacramento.....		10
Hooker, G. W., Lockeford.....		24				Johnson, H. S., Long Beach.....		10
Hooker, M. O., Santa Barbara.....		27				Johnson, J. K., Culver City.....		10
Hooval, J. H., Ontario.....		21				Johnson, L. C., Salinas.....		14
Hoover, E. F., San Diego.....		22				Johnson, M., Los Angeles.....		10
Hoover, J. N., Long Beach.....		10				Johnson, M. L., Oakland.....		1
Hope, R. B., Los Angeles.....		10	Iann, C. L., San Jose.....		28	Johnson, N. P., Stockton.....		24
Hopkins, E. K., San Francisco.....		23	Iki, G. S., Sacramento.....		19	Johnson, O. D., Los Angeles.....		10
Hopkins, H., Los Angeles.....		10	Illick, C. R., Santa Paula.....		37	Johnson, O. F., Sacramento.....		19
Hopkins, J. J., San Francisco.....		23	Ilisley, M. L., Claremont.....		10	Johnson, P., San Francisco.....		23
Hopkins, J. W., Glendale.....		10	Imerman, C. P., Hollywood.....		10	Johnson, R., Compton.....		10
Hopkins, M. A., Sacramento.....		19	Imerman, S. W., Hollywood.....		10	Johnson, R. H., Los Angeles.....		10
Hopkins, M. F., San Jose.....		28	Imler, H. G., Los Angeles.....		10	Johnson, R. L., Westminster.....		16
Hopkirk, C. C., Santa Monica.....		10	Ing, C. S., Stockton.....		24	Johnson, R. W., Corona.....		18
Horn, C. E., San Francisco.....		23	Ingalls, A. T., Los Angeles.....		10	Johnson, R. W., San Fernando.....		10
Horner, C. D., San Francisco.....		23	Inger, I. S., San Francisco.....		23	Johnson, S. P., Los Angeles.....		10
Horner, H. E., West Los Angeles.....		10	Ingels, A. E., San Francisco.....		21	Johnson, W. A., Antioch.....		3
Horner, W. D., San Francisco.....		23	Ingham, R. O., Colton.....		23	Johnson, W. C., Pomona.....		10
Horst, W. W., Wilmington.....		10	Ingham, S. D., Los Angeles.....		21	Johnson, W. E., Santa Barbara.....		27
Horton, F. L., Pomona.....		10	Inghram, H. D., San Bernardino.....		10	Johnson, W. T., Alhambra.....		10
Horwitz, H., Oakland.....		1	Ingram, C. H., Fresno.....		4	Johnston, E. J., South Pasadena.....		10
Hosford, G. N., San Francisco.....		23	Inman, M. M., Los Angeles.....		10	Johnston, F. R., Oakland.....		1
Hoskins, G., Long Beach.....		10	Inman, T. G., San Francisco.....		23	Johnston, H. A., Anaheim.....		16
Hoskins, G. T., Hollywood.....		4	Innis, E. C., Newhall.....		10	Johnston, J., Los Angeles.....		10
Hoskins, H. D., San Diego.....		22	Iriki, W. K., Oakland.....		1	Johnston, S. T., National City.....		16
Hosmer, C. M., San Diego.....		22	Irish, C. W., Los Angeles.....		10	Johnston, W. H., Santa Barbara.....		27
Hosmer, M. N., San Francisco.....		23	Irvine, A. R., Los Angeles.....		10	Johnstone, G. A., Los Angeles.....		10
			Irvine, R. S., San Francisco.....		23	Johnstone, E. M., Pasadena.....		10
			Irvine, S. R., Los Angeles.....		10	Johnstone, W. A., Hanford.....		8

COUNTY			COUNTY			COUNTY		
NAME	CITY	SOCIETY NO.	NAME	CITY	SOCIETY NO.	NAME	CITY	SOCIETY NO.
Jones, A. A., Long Beach.....		10	Kellogg, E. C., Los Angeles.....		10	Kocher, R. A., Carmel.....		14
Jones, C. B., Sacramento.....		19	Kellogg, F., Long Beach.....		10	Koda, K., Watsonville.....		29
Jones, C. P., Grass Valley.....		17	Kellogg, J. O., San Diego.....		22	Koebig, W. C. S., Los Angeles.....		10
Jones, C. R., San Diego.....		22	Kelly, A. L., Oceanside.....		22	Koefod, H. O., Santa Barbara.....		27
Jones, E. F., Oakland.....		1	Kelly, E. E., Pomona.....		10	Koehler, A. E., Santa Barbara.....		27
Jones, E. M., Los Angeles.....		10	Kelly, T. H., San Francisco.....		23	Koenecke, H. J., Salinas.....		14
Jones, E. W., Pasadena.....		10	Kelsey, T. W., Sacramento.....		19	Koepke, F. H., Watsonville.....		29
Jones, E. W., Los Angeles.....		10	Kelso, G. C., Pittsburg.....		3	Koetter, G. F., Los Angeles.....		10
Jones, G. F., San Francisco.....		23	Kelso, R. W., Long Beach.....		10	Koford, H., Oakland.....		1
Jones, G. W., Los Angeles.....		10	Kemp, D. H., San Francisco.....		23	Kohlenberger, C. F. W., Fullerton.....		16
Jones, H. T., Los Angeles.....		10	Kemper, C. A. S., Escondido.....		22	Kohlhase, L. H., Los Angeles.....		10
Jones, H. W., Bakersfield.....		7	*Kendall, O. J., San Diego.....		22	Kohlmoos, H. J., Oakland.....		1
Jones, I. H., Los Angeles.....		10	Kennedy, C. R., Paso Robles.....		25	Kohls, C. L., San Francisco.....		23
Jones, I. W., Los Angeles.....		10	Kennedy, K. E., Oakland.....		1	Kohn, F., Tulare.....		36
Jones, J. C., Los Angeles.....		10	Kennedy, W. J., Oakland.....		1	Kolb, H. J., Oakland.....		1
Jones, J. P., Los Angeles.....		10	Kennell, L. A., San Diego.....		22	Kolda, F. O., Alhambra.....		1
Jones, J. R., Sacramento.....		19	Kenny, E. W., Oakland.....		1	Kolisch, J. M., Los Angeles.....		10
Jones, J. W., San Francisco.....		23	Kennicott, R. H., Los Angeles.....		10	Konantz, O. F., Hollywood.....		10
Jones, K. P., Olive View.....		20	Kerlan, M., Beverly Hills.....		10	Konigsmacher, A. H., Fresno.....		4
Jones, L. E., Roseville.....		17	Kern, B. C., Jackson.....		19	Konttas, P. V., Santa Rosa.....		33
Jones, L. L., Glendale.....		10	Kerns, C. L., Pittsburg.....		3	Koplin, H., Los Angeles.....		10
Jones, N., Los Angeles.....		10	Kerr, W. J., San Francisco.....		23	Kopclowitz, J. C., Los Angeles.....		10
Jones, N., Sacramento.....		19	Kersten, E. H. W., Anaheim.....		16	Korshet, M., San Francisco.....		23
Jones, O. C., Santa Maria.....		27	Kersten, H. M., Los Angeles.....		10	Kortheuer, K. H., Calexico.....		6
Jones, O. W., San Anselmo.....		11	Keser, M. D., Richmond.....		3	Kosky, A. A., Santa Monica.....		10
Jones, O. W., Jr., San Francisco.....		23	Kessler, E. E., Los Angeles.....		10	Kosky, A. W., Santa Monica.....		10
Jones, R. A., San Francisco.....		23	Key, J. D., El Centro.....		6	Kosterlitz, E., Berkeley.....		1
Jones, R. B., San Francisco.....		23	Key, W. A., San Mateo.....		26	Kracaw, F. C., Oakland.....		1
Jones, R. M., Bakersfield.....		7	Keyes, H. R., Los Angeles.....		10	Kraft, R. W., Pasadena.....		10
Jones, R. M., Ventura.....		37	Kibbe, M. E., Oakland.....		1	Krahulik, E. J., Hollywood.....		10
Jones, S. C., San Francisco.....		23	Kibby, S. V., Los Angeles.....		10	Kramar, L. G., Fortuna.....		5
Jones, W. A., Riverside.....		18	Kidder, F. W. K., Los Angeles.....		10	Kraushaar, J. C., Garden Grove.....		16
Jones, W. H., Long Beach.....		10	Kiger, W. H., Los Angeles.....		10	Kreinman, S. G., Los Angeles.....		10
Jones, W. H. G., Los Gatos.....		28	Kilbourne, N. J., Los Angeles.....		10	Kremers, E. D., Pasadena.....		10
Jones, Z. G., Long Beach.....		10	Kilcher, C. W., Sacramento.....		19	Kress, G. H., Los Angeles.....		10
Jordan, P. A., San Jose.....		28	Kilduff, R., Oroville.....		2	Kretzschmar, K. E., Los Angeles.....		10
Jorgensen, S. N., San Francisco.....		23	Kille, R. F., San Francisco.....		23	Kristensen, W. A., Los Angeles.....		10
Jorgenson, N., Fresno.....		4	Kilfoy, E. J., Los Angeles.....		10	Kreutzmann, H. A. R., San Francisco.....		23
Josephs, I. L., Los Angeles.....		10	Kilgore, A. M., Hollywood.....		23	Kroener, W. F., Whittier.....		10
Josephs, L., Los Angeles.....		10	Kilgore, A. R., San Francisco.....		23	Kroger, W. P., Los Angeles.....		10
Josephson, J. B., San Jose.....		28	Kilgore, E. S., San Francisco.....		23	Krohn, H. N., Los Angeles.....		10
Joyce, T. F., Spadra.....		10	Kilgore, G. L., San Diego.....		22	Kroll, F. W., San Francisco.....		23
Judd, G. E., Los Angeles.....		10	Kimball, T. S., Glendale.....		10	Krout, B. M., Stockton.....		24
Judge, W. D., Los Angeles.....		10	Kimberlin, L. O., San Francisco.....		23	Krueger, A. P., Berkeley.....		1
Judson, H. A., Los Angeles.....		10	Kindall, C. E., Los Angeles.....		10	Krugmeier, C. E., Los Angeles.....		10
Juenemann, G. F., Los Angeles.....		10	Kindall, L. E., Oakland.....		17	Krull, F., Sacramento.....		19
Julien, A. E., Turlock.....		34	Kindopp, D. M., Auburn.....		1	Kruse, F. H., San Francisco.....		23
Jumpblatt, A., Pacific Beach.....		22	King, C. S., Los Angeles.....		10	Kruse, F. L., San Francisco.....		23
Jump, K., San Mateo.....		26	King, D. E., San Francisco.....		23	Kryder, G. B., Glendale.....		10
- K -			King, E. B., Arroyo Grande.....		25	Kuder, W. S., Oakland.....		1
Kaelber, A. P., San Francisco.....		23	King, E. H., Tujunga.....		10	Kuhlman, M. B. K., Mid Pines.....		13
Kaffesieder, L. I., Los Angeles.....		10	King, H. R., Winters.....		38	Kuhlmann, F. W., Long Beach.....		10
Kaftan, L. L., Los Angeles.....		10	King, J. A., Ojai.....		37	Kuhn, O. E., Inglewood.....		24
Kahl, C. W., Merced.....		13	King, J. C. E., San Diego.....		22	Kulaev, A. A. M., San Francisco.....		23
Kahler, A. R., Sacramento.....		19	King, J. M., Los Angeles.....		10	Kulchar, G. V., San Francisco.....		23
Kahn, H., Santa Maria.....		27	King, N. C., Los Angeles.....		10	Kully, B. M., Los Angeles.....		10
Kahn, J., Los Angeles.....		10	King, W., Chico.....		2	Kurtz, C., Los Angeles.....		10
Kahn, M. G., Los Angeles.....		10	Kinkade, J. M., Inglewood.....		10	Kusel, E. A., Oroville.....		2
Kalfus, J. L., Santa Maria.....		27	Kinney, L. C., San Diego.....		22	Kutzmann, A. A., Los Angeles.....		10
Kalichman, G. S., Santa Monica.....		10	Kinney, M. A. J., Los Angeles.....		10	Kyddson, T. W., Linden.....		24
Kanagawa, H. H., Stockton.....		24	Kinney, P. E., Pasadena.....		10	- L -		
Kane, L. M., Los Angeles.....		10	Kinslow, F. A., San Francisco.....		23	Lacayo, J. R., Los Angeles.....		10
Kanner, H. M., Sacramento.....		19	Kinzer, E. E., South Pasadena.....		10	Lacey, J. M., Los Angeles.....		10
Kaplan, H. E., Stockton.....		23	Kirby, J. M., Bakersfield.....		7	Lacey, L. E., Oakland.....		1
Kaplan, M., Los Angeles.....		10	Kirchner, A. A., Los Angeles.....		10	Lacey, M. J., Albany.....		1
Kapp, M. W., San Jose.....		28	Kirchner, H. J., Los Angeles.....		10	Lachman, G. S., San Francisco.....		23
Kaps, F. O., Santa Ana.....		16	Kirchoff, J. J., Los Angeles.....		10	*Lackey, H. J., Oakland.....		1
Karfiol, G. I., San Francisco.....		23	Kirk, A. W., San Francisco.....		23	Lackner, L., San Jose.....		28
Karo, H. L., Grass Valley.....		17	Kirk, J. H., Palo Alto.....		28	Lacoe, J. R., Los Angeles.....		10
Karr, M., Sonoma.....		24	Kirk, M. E., Oakland.....		1	Lafontaine, E. C., San Francisco.....		23
Karras, R. W., Milwaukee, Wis.....		10	Kirkle, O. L., Napa.....		15	*Lagan, E., San Francisco.....		23
Karshner, R. G., Los Angeles.....		10	Kirkpatrick, J. E., Los Angeles.....		10	Laist, O., San Francisco.....		23
Katz, B., Los Angeles.....		10	Kirkpatrick, J. H., Los Angeles.....		10	Lajoie, R. J., Los Angeles.....		10
Kaufman, B., San Francisco.....		23	*Kirkpatrick, J. L., Los Angeles.....		10	Lake, T. O., Berkeley.....		1
Kavanagh, M. F., San Francisco.....		23	Kirsch, R. L., Pasadena.....		12	Lakey, W. J., Canoga Park.....		10
Kavinoky, N. R., Los Angeles.....		10	Kirwin, J. J., Ukiah.....		12	Lamb, E. J., Santa Barbara.....		27
Kay, G. L., Redding.....		30	Kiser, A. E., Imola.....		15	Lamb, L. M., Oakland.....		1
Kay, M. M., Shafter.....		7	Kiskadden, W. S., Los Angeles.....		10	Lamb, W. K., Berkeley.....		1
Kay, R., Los Angeles.....		10	Kistinger, W. F., Santa Ana.....		16	Lambert, H. W., Oakland.....		1
Kay, W. E., Jr., San Francisco.....		23	Kistler, R. H., San Francisco.....		23	Lambertson, E. R., Los Angeles.....		10
Kaysen, R., San Diego.....		22	Kitagawa, K. J., San Francisco.....		23	Lambuth, R. W., Santa Barbara.....		27
Kearney, F. K., Hayward.....		1	Kitsuda, F. Y., Sacramento.....		19	La Mont, W., Beverly Hills.....		10
Kearney, W. B., San Francisco.....		23	Kittridge, F. McN., Los Angeles.....		10	La Motte, L. A. J., Los Angeles.....		10
Keating, V. J., Los Angeles.....		10	Kjaerbye, C. P. H., Fresno.....		4	Lamson, M., Palo Alto.....		28
Keeler, N. S., Oakland.....		1	Klein, I., Los Angeles.....		10	Lamson, R. W., Los Angeles.....		10
Keenan, A. S., San Francisco.....		23	Klein, J. M., No. Hollywood.....		19	Lancaster, J. S., Torrance.....		10
Keeney, M. J., Los Angeles.....		10	Klick, J. J., Sacramento.....		19	Landegger, G. F., Los Angeles.....		10
Kehoe, E. J., San Mateo.....		26	Kliman, F. E., Los Angeles.....		10	Landis, C. C., Chico.....		2
Kehr, E. F., Carmel.....		14	Kling, D. H., Los Angeles.....		10	Lando, M. E., Oakland.....		1
Keifer, G. F., Beverly Hills.....		10	Klotz, N. C., San Francisco.....		27	Landon, G. S., San Bernardino.....		21
Keith, C. F., Williams.....		38	Kluss, E. R., Santa Barbara.....		23	Landrock, G. M., Mill Valley.....		11
Kelker, G. D., San Luis Obispo.....		25	Klussman, H. O. G. T., San Francisco.....		23	Lane, C. R., Los Angeles.....		10
Kell, F. B., San Bernardino.....		21	Knapp, E. V., Foss.....		11	Lane, C. W., Coronado.....		22
Keller, F., Los Angeles.....		10	Kneeshaw, R. S., San Jose.....		28	Lane, E. H., Los Angeles.....		10
Keller, S. H., Riverside.....		18	Knight, L. C., San Francisco.....		23	Lane, J. A., Eureka.....		5
Kelley, E. H., San Diego.....		22	Knoll, R. F., Los Angeles.....		10	Lang, J. H., Fullerton.....		16
Kelley, H. W., Oakland.....		1	Knoph, B. W., Brentwood.....		24	Langan, A. J., San Pedro.....		10
Kelley, J. W., Los Angeles.....		10	Knorr, W. F., Burlingame.....		26			
			Knox, L. R., Concord.....		3			
			Knox, C. R., El Cajon.....		22			
			Knox, L. M., Carmel.....		14			

COUNTY			COUNTY			COUNTY		
NAME	CITY	SOCIETY NO.	NAME	CITY	SOCIETY NO.	NAME	CITY	SOCIETY NO.
Langdon, E. E., Santa Monica.....	10	Lewis, S. A., Hollywood.....	10	Luisignan, H. R., Monterey.....	14			
Langdon, S. W. R., Stockton.....	24	Libby, A. A., Pasadena.....	10	Luton, G. R., Santa Barbara.....	27			
Lange, H. W., Bakersfield.....	8	Liddell, E. B., Los Angeles.....	10	Lyle, A. G., San Francisco.....	23			
Langer, J., Hilt.....	31	Lien, F. O., Merced.....	13	Lyman, G. D., San Francisco.....	23			
Langley, R. W., Los Angeles.....	10	Liles, L. M., Watsonville.....	29	Lyman, T., Sacramento.....	19			
Langlois, L. J., San Diego.....	22	Lilienthrant, G. H., Oakland.....	1	Lynch, D. A., Omaha, Nebraska.....	10			
* Langnecker, H. L., San Francisco.....	23	Liljedahl, E. N., Los Angeles.....	10	Lynch, F. W., San Francisco.....	23			
Langstroth, L., San Francisco.....	23	Liljencrantz, E., San Francisco.....	23	Lynch, W. P., Stockton.....	24			
Lanphere, G. H., Los Angeles.....	10	Lilley, W. E., Merced.....	13					
Larkey, J., Oakland.....	1	Linde, F. G., San Francisco.....	23					
Larner, T. E., Marysville.....	39	Lindberg, A. L., Los Angeles.....	10					
Larsen, A. E., San Francisco.....	23	Lindberg, A. W., Los Angeles.....	10					
Larsen, E., Los Angeles.....	10	Lindemulder, F. G., San Diego.....	22					
Larsen, J. W., Paso Robles.....	25	Lindenberg, F., Los Angeles.....	10					
Larsen, L. H., Point Reyes.....	11	Lindner, H. H., San Francisco.....	23					
Larson, A. H., Los Angeles.....	10	Lindquist, C. A., Los Angeles.....	10					
Larson, C. F., Sausalito.....	11	Lindquist, E. N., Culver City.....	10					
Larson, E. A., Kingsburg.....	4	Lindroth, E., Long Beach.....	10					
Larson, E. E., Los Angeles.....	10	Lindsay, C. V., Encinitas.....	22					
Lartigau, A. J., San Francisco.....	23	Lindsay, H. C. L., Hollywood.....	10					
Lasswell, B. J., Redwood City.....	9	Linsday, J. O., Santa Monica.....	10					
Laton, G. P., Los Angeles.....	10	Linsley, St. C. R., Los Angeles.....	10					
* Latta, S. E., Stockton.....	24	Linear, A. S., Los Angeles.....	10					
Laubershelmer, G. A., Los Angeles.....	10	Linhart, L. R., Los Angeles.....	10					
Lauder, C. H., Los Angeles.....	10	Linn, J. L., Glendale.....	10					
Lauer, C. A., Long Beach.....	10	Linthicum, F. H., Los Angeles.....	10					
Laughlin, T. J., Hollywood.....	10	Lipkis, A., Los Angeles.....	10					
Lavery, W. A., Loyaltan.....	17	Lipp, M. J., Sacramento.....	19					
Law, C. H., Elgin, Oregon.....	30	Lippman, M. H., San Francisco.....	23					
Lawler, P. W., Victorville.....	21	Lipsett, E. M., San Francisco.....	23					
Lawler, W. H., Salinas.....	14	Lipsett, P. J., Oakland.....	1					
Lawrence, L. B., Oakland.....	1	Lipson, B., Los Angeles.....	10					
Lawrence, W., San Francisco.....	23	Lipson, I. M., Visalia.....	36					
Lawson, J. D., Sacramento.....	19	Lischnier, H., Los Angeles.....	10					
Lawson, T. C., Oakland.....	1	Lisser, H., San Francisco.....	23					
Lawyer, P. C., Inglewood.....	10	Lissner, H. H., Los Angeles.....	10					
Layman, M. H., San Francisco.....	23	Lista, L. J., San Francisco.....	31					
Lazard, E. M., Los Angeles.....	10	Liston, E., Palo Alto.....	28					
Lazelle, H. G., La Jolla.....	22	Litchfield, H., Los Angeles.....	10					
Leach, C. W., Kelseyville.....	12	Little, E. W., Los Angeles.....	10					
Leach, W. O., Glendale.....	10	Little, R. P., Santa Paula.....	37					
Leachman, R. S., Vallejo.....	32	Lloyd-Jones, O., Los Angeles.....	10					
Leake, N. A., Torrance.....	10	Lockwood, M. S., National City.....	22					
Leake, W. H., Los Angeles.....	10	Lodge, E. S., Los Angeles.....	10					
Leavitt, A. S., Los Angeles.....	10	Loe, H. D., Oakland.....	1					
Leavitt, F. J., Los Angeles.....	10	Loehr, B. E., San Jose.....	28					
Le Baron, R. O., Talmage.....	12	Logan, N. H., Oakland.....	1					
Ledford, R. M., San Diego.....	22	Logsdon, R. O., San Diego.....	22					
Ledyard, C. C., Los Angeles.....	10	Lohmann, H. G., Oakland.....	1					
Lee, D., San Jose.....	28	Lohse, J. L., Oakland.....	1					
Lee, E. C., San Diego.....	22	Loizeaux, E. S., San Diego.....	22					
Lee, F. J., Santa Monica.....	10	Lokrantz, S. R., Los Angeles.....	10					
Lee, F. W., Sacramento.....	19	Loneragan, L., Loma Linda.....	21					
Lee, H., San Jose.....	28	Long, F. E., Los Angeles.....	10					
Lee, L. H., Los Angeles.....	10	Long, H. E., Berkeley.....	1					
Lee, R. V. A., Palo Alto.....	28	Long, S. C., Bakersfield.....	7					
Leef, E., San Francisco.....	23	Loomis, F. M., Oakland.....	1					
Leef, N. B., Oakland.....	1	Loomis, N. M., Yuba City.....	39					
Leet, R. S., Oakland.....	1	Loos, H. C., Los Angeles.....	10					
Leete, C. M., Pasadena.....	10	Looser, R. V., Hollywood.....	10					
Leffingwell, F. E., Montebello.....	10	Lopez, C. J., Hollywood.....	10					
Leffler, A. B., Los Angeles.....	10	Lopez, E. A., San Leandro.....	1					
Leftwich, O. T., Oakland.....	1	Lopizich, I. J., Los Angeles.....	10					
Legge, R. T., Berkeley.....	1	Lord, D. C., Paradise.....	2					
Leggitt, R. C., Glendale.....	10	Lordan, J. P., Los Angeles.....	10					
Leggo, R. C., Crockett.....	3	Lorentz, R., Jr., San Francisco.....	23					
Leidig, L. R., Los Angeles.....	36	Lorenz, H. E., Sacramento.....	19					
Leimbach, J. H., Isleton.....	18	Loring, F. W., Glendale.....	10					
Leland, H. G., Klamath.....	5	Loughlin, E. L., Los Angeles.....	10					
Leland, S., San Francisco.....	23	Lounsberry, C. R., San Diego.....	22					
Lemere, H. B., Beverly Hills.....	10	Loutzenhelsler, J. J., San Francisco.....	23					
Lenker, W. D., San Bernardino.....	21	Love, A. A., Los Angeles.....	10					
Lennon, M. B., San Francisco.....	23	Love, C. A., Jr., San Bernardino.....	21					
Lennon, T. J., San Francisco.....	23	Love, E. C., Calistoga.....	15					
Leon, T. D., Concord.....	3	Lovejoy, E. D., Los Angeles.....	10					
Leonard, A. T., San Francisco.....	23	Lovell, H. O., Placerville.....	19					
Leonard, E. M., San Francisco.....	23	Lovely, J. P., San Jose.....	28					
Leonard, J. V., San Francisco.....	23	Loven, S. M., Keene.....	23					
Leonard, W. E., Los Angeles.....	10	Loveren, G. S., Santa Barbara.....	27					
Lepper, L. E., Los Angeles.....	10	Low, T. C., Los Angeles.....	10					
Lerned, M. B., Pasadena.....	10	Lowe, F. A., San Francisco.....	23					
Lesem, A. M., San Diego.....	22	Lowman, C. L. R., Los Angeles.....	10					
Lettice, F. E., Los Angeles.....	10	Lubin, M. L., San Francisco.....	23					
Leuschner, C. E., Los Angeles.....	10	Lucas, W., Los Angeles.....	10					
Levin, E. A., San Francisco.....	23	Lucas, W. P., San Francisco.....	23					
Levin, H. A., Los Angeles.....	10	Lucas, W. S., Richmond.....	3					
Levin, M. A., Los Angeles.....	10	Lucey, D. D., Los Angeles.....	10					
Levin, W. N., Avenal.....	4	Lucia, S. P., San Francisco.....	23					
Levison, C. G., San Francisco.....	23	Luckie, J. B., Pasadena.....	10					
Levitin, J., Sausalito.....	23	Luechauer, K. D., Fresno.....	4					
Leviton, H. I., Los Angeles.....	10	Lum, D. D., Alameda.....	1					
Levy, E. I., San Diego.....	23	Lum, P. A., Carmel.....	14					
Levy, J. J., Los Angeles.....	4	Lumley, C. G., Huntington Park.....	10					
Levy, M. L., Los Angeles.....	10	Lumsden, A. G., Petaluma.....	33					
Lewe, G. H., Los Angeles.....	10	*Lund, C. W., Willows.....	38					
Lewis, C. E., Auburn.....	17	Lund, Le V., Los Angeles.....	10					
Lewis, C. H., Santa Monica.....	10	Lundegaard, E. E., Wetmar.....	17					
Lewis, J. D., Santa Barbara.....	27	Lundegaard, E. M., Oakland.....	1					
Lewis, K., Beverly Hills.....	10	Lundquist, D. T., Palo Alto.....	23					
Lewis, L. R., Los Angeles.....	10	Lunsford, C. J., Oakland.....	1					
Lewis, M. L., Petaluma.....	33	Lupton, E. L., Los Angeles.....	10					
Lewis, N. H., Hollywood.....	10	Lurie, S. A., Los Angeles.....	10					

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Marquis, C. E.,	Oakland	1	McCool, J. L.,	San Francisco	23	Meade, F. J.,	Los Angeles	10
Marr, J. B.,	Covina	10	McCool, W. F.,	Los Angeles	10	Meads, A. M.,	Oakland	1
Mariotti, J. L.,	Alameda	1	McCorkle, H. J.,	Cincinnati, Ohio	23	Meals, R. W.,	Los Angeles	10
Marsden, C. S.,	San Diego	22	McCoskey, G.,	Stockton	24	Means, P. C.,	Santa Barbara	27
Marsden, S. A.,	Santa Ana	16	McCoy, C. A.,	Los Angeles	10	Meherin, J. M.,	San Francisco	23
Marsh, C.,	Sebastopol	33	McCoy, E. T.,	Los Angeles	10	Mehlin, G. B.,	San Diego	22
Marsh, O. G.,	San Diego	22	McCoy, H. H.,	Long Beach	10	Mehrmann, H. B.,	Oakland	1
Marshall, B. M.,	Eureka	5	McCracken, J. H.,	San Pedro	10	Meininger, W. M.,	San Francisco	23
Marshall, H. K.,	Glendale	10	McCradie, R. D.,	Oakland	1	Meland, O. N.,	Los Angeles	10
Marshall, J. M.,	San Luis Obispo	25	McCrea, F. R.,	Long Beach	10	Melkonian, L.,	Gilroy	28
Marston, O. C.,	Watsonville	29	McCue, J. E.,	San Francisco	34	Mell, C. N.,	Oakland	1
Marston, C. B.,	San Rafael	11	McCullough, F. E.,	Berkeley	1	Mellinger, H. V.,	Los Angeles	10
Marston, H. E.,	San Rafael	11	McCullough, J. M.,	Crockett	3	Mellinger, W. J.,	Santa Barbara	27
Martin, A. T.,	Los Angeles	10	McCuskey, C. F.,	Los Angeles	10	Melnik, M.,	Los Angeles	10
Martin, G. S.,	Susanville	9	McDermott, J. C.,	Los Angeles	10	Mendelsohn, L.,	Saratoga	28
Martin, H. W.,	Los Angeles	10	McDonald, A. C.,	Huntington Park	10	Meneray, P. A.,	Santa Rosa	33
Martin, J. J.,	Long Beach	10	McDonald, F. X.,	Los Angeles	10	Mensor, M. C.,	San Francisco	23
Martin, J. P.,	Oakland	1	McDonald, G. H.,	Ocean Beach	22	Mentzer, M. J.,	San Francisco	23
Martin, L. A.,	Berkeley	1	McDonald, J.,	San Francisco	23	Mentzer, S. H.,	San Francisco	23
Martin, L. E.,	Los Angeles	10	McDonnell, C. H.,	Sacramento	19	Meredith, H. H.,	Oakland	1
Martin, M. L.,	Los Angeles	10	McDowell, B. E.,	Merced	13	Merkle, H. J.,	Los Angeles	10
Martin, P. T.,	San Jose	28	McDowell, C. A.,	Covina	10	Mermod, L. E.,	Lanai City, Lanai	3
Martin, R. C.,	San Francisco	23	McElhinney, P. P. B.,	Long Beach	10	T. H.,		3
Martin, R. C.,	San Bernardino	21	McEvers, A. E.,	Los Angeles	10	Merrill, A. P.,	San Francisco	23
Martine, A.,	La Jolla	22	McFarlane, A. H.,	Mountain View	25	Merrill, B. E.,	Oakland	1
Martins, S. M.,	Los Angeles	10	McGarvey, H.,	Atascadero	23	*Merrill, E. R.,	Santa Barbara	27
Martyn, G.,	Los Angeles	10	McGee, R. P.,	Los Angeles	10	Merrill, H. G.,	San Diego	22
Marx, R.,	Los Angeles	10	McGee, W. B.,	San Diego	22	Merrill, H. P.,	Los Angeles	10
Marxer, W. L.,	Beverly Hills	10	McGehee, W. H.,	Fresno	4	Merrill, J. A.,	Monterey	14
Marxmillier, H. G.,	Los Angeles	10	McGibbon, D.,	Los Angeles	10	Merrill, R. E.,	Burbank	10
Mason, B. B.,	Laguna Beach	16	McGill, P. R.,	Hollywood	10	Merrill, W. I.,	Campbell	28
Mason, B. S.,	San Jose	28	McGinnis, J. J.,	New York	23	Merrithew, E. W.,	Martinez	3
Mason, C. V.,	Livermore	1	McGovern, B. E.,	San Fernando	22	Mesriow, M. E.,	Santa Maria	27
Mason, H. E.,	Redwood City	26	McGovney, R. B.,	Santa Barbara	27	Mettier, S. R.,	San Francisco	23
Mason, H. M.,	Los Angeles	10	McGranahan, J. H.,	Long Beach	10	Meuser, A. H.,	Corning	35
Mason, M. L.,	San Jose	28	McGrath, A. K.,	Sonoma	15	Meyenberg, W. D.,	Salinas	14
Mason, V. R.,	Los Angeles	10	McGraw, L. S.,	San Luis Obispo	25	Meyer, A. J.,	Glendale	10
Massey, B. D.,	Pasadena	10	McGreene, F. X.,	Calistoga	15	Meyer, H.,	San Francisco	23
Masters, E. J.,	San Francisco	23	McGrew, W. R.,	Oakland	1	Meyer, W. F.,	San Diego	22
Masterston, J. R.,	Berkeley	1	McGuinness, J. E.,	San Francisco	23	Meyers, E. L.,	Chico	2
Mathé, C. P.,	San Francisco	23	McGuinness, J. S.,	San Francisco	23	Meyers, E. M.,	Oakland	1
Mather, R. W.,	Los Angeles	10	McGuire, F. A.,	Stockton	24	Michael, L.,	San Leandro	1
Mathes, M. E.,	San Francisco	23	McGuire, J. J.,	San Francisco	23	Michael, P. P.,	Oakland	1
Mathews, S. S.,	Los Angeles	10	McGuire, T. E.,	Burbank	10	Michelson, L.,	San Francisco	23
Mathewson, C.,	Fresno	4	McGurk, R. T.,	Stockton	24	Mikels, B. M.,	Long Beach	10
Mathewson, C., Jr.,	San Francisco	23	McHugh, J. A.,	Stockton	24	Mikels, F. M.,	Palms	10
Mathias, C. M.,	Tulare	36	McHugh, P. H.,	Stockton	24	Miles, R. H.,	Alameda	1
Matlock, T. T.,	Wasco	7	McHugh, T. R.,	Los Angeles	10	Miles, S. H.,	Olive View	10
Matousek, W. J.,	Glendale	10	McIntosh, A. M.,	Berkeley	1	Milholand, W. G.,	Fresno	4
Matson, J. R.,	San Diego	22	McKay, J. J.,	San Francisco	23	Miller, G. E.,	Sacramento	19
*Matsumura, K.,	San Francisco	23	McKee, C. B.,	Sacramento	19	Miller, A.,	San Rafael	11
Mattison, C. W.,	Los Angeles	10	McKee, E. N.,	Eagle Rock	10	Miller, A. H.,	Los Angeles	10
Mattison, S. J.,	Pasadena	10	McKee, K. S.,	Bakersfield	7	Miller, A. V.,	Porterville	36
Matzger, E.,	San Francisco	23	McKee, W. C.,	Los Angeles	10	Miller, A. W.,	Riverside	18
Maupin, J. L., Jr.,	Fresno	4	McKeehan, G. O.,	Los Angeles	10	Miller, B. F.,	Yuba-Sutter	39
Mawdsley, H. L.,	San Mateo	26	McKeever, F. M.,	Los Angeles	10	Miller, C. D.,	Glendale	10
Maxson, E. S.,	Alhambra	10	McKellar, J. H.,	Pasadena	10	Miller, C. M., Jr.,	Olive View	10
Maxwell, A. H.,	Sausalito	11	McKelvy, R. W.,	Los Angeles	10	Miller, D. G.,	Los Angeles	10
Maxwell, R. E.,	Modesto	34	McKenna, W. J.,	Los Angeles	10	Miller, E. P.,	Riverside	18
May, H. C.,	Los Angeles	10	McKenney, J. A.,	Oakland	1	Miller, F. F.,	San Diego	22
May, J. A.,	San Diego	22	McKenney, P. W.,	Alturas	9	Miller, F. P.,	Los Angeles	10
May, L. B.,	Bakersfield	7	McKenzie, C. R.,	Oakland	1	Miller, F. W.,	Los Angeles	10
Mayer, H. J.,	Los Angeles	10	McKenzie, R. B.,	San Francisco	23	Miller, H.,	Los Angeles	10
Mayers, M. M.,	Los Angeles	10	McKibbin, J.,	Los Angeles	10	Miller, H. A.,	Alameda	1
Mayfield, C.,	Long Beach	10	McKinnon, A. A.,	Placerville	19	Miller, H. A.,	Los Angeles	10
Mayman, E.,	Modesto	34	McKinnon, D. D.,	Los Angeles	10	Miller, H. E.,	San Francisco	23
Maynard, M. T.-R.,	San Jose	28	McKnight, W. B.,	Portola	9	Miller, H. R.,	Chico	21
Mays, A. H.,	Sausalito	11	McLain, L. C.,	Bakersfield	7	Miller, I. S.,	Colton	21
McAllister, H. R.,	Taft	7	McLaughlin, R. C.,	Los Angeles	10	Miller, J. E.,	Los Angeles	10
McAllister, O. O. T.,	Oakland	1	McLaughlin, T. H.,	Hollywood	10	Miller, J. J., Jr.,	San Francisco	23
McAnally, J. F.,	Roseville	17	McLean, D.,	Sacramento	19	Miller, L. G.,	Imola	15
McArthur, D. D.,	Los Angeles	10	McLelsh, A. H.,	Yountville	15	Miller, N.,	Porterville	36
McArthur, P. R.,	Los Angeles	10	McLellan, G. H.,	San Diego	22	Miller, P. D.,	Dimuba	36
McAtee, J. S.,	Los Angeles	10	McLeod, F. L.,	Los Angeles	10	Miller, R. B.,	Glendale	10
McAuley, J.,	Santa Ana	16	McLeod, J. H.,	Santa Rosa	33	Miller, R. F.,	Los Angeles	10
McBride, R. W.,	Burlingame	26	McManus, F. P.,	Esparto	38	Miller, R. R.,	Pasadena	10
McBurney, B. A.,	Pomona	10	McMaster, P. E.,	Los Angeles	10	Miller, R. W.,	Los Angeles	10
McBurney, R. D.,	Los Angeles	10	McMeekin, H. R.,	Lynwood	10	Miller, S. J.,	Long Beach	10
McCallister, C. H.,	Los Angeles	10	McMillan, E. H.,	Pasadena	23	Miller, T.,	San Diego	22
McCann, F. E.,	Monrovia	10	McMurdoo, P. F.,	San Francisco	23	Miller, T. K.,	Patton	21
McCarthy, A. M.,	Los Angeles	10	McMurtry, M. S.,	Clavis	4	Miller, W. J.,	Los Angeles	10
McCarthy, F. J.,	San Francisco	23	McNab, T. R.,	Los Angeles	10	Miller, W. McC.,	Auburn	17
McCarthy, H. L.,	Los Angeles	10	McNamara, D. H.,	Santa Barbara	27	Milliken, J. H.,	Oakland	1
McCarthy, J. B.,	Carmel	14	McNaught, J. B.,	San Francisco	23	Milliken, W. F.,	Oakland	1
McCartney, O. D.,	Glendale	10	McNaught, R. C.,	San Francisco	23	Mills, L.,	Los Angeles	10
McCarty, R. B.,	Riverside	18	McNeill, D.,	Sacramento	19	Mills, W.,	Oakland	1
McCauley, A. M.,	Los Angeles	10	McNeill, H. G.,	Los Angeles	10	Mills, W. W.,	San Mateo	26
McCauley, W. S.,	Chula Vista	22	McNeill, W. T.,	Stockton	24	Millspaugh, W. P.,	Los Angeles	10
McChesney, G. J.,	San Francisco	23	McNelle, L. G.,	Los Angeles	10	Millzner, R. J.,	San Francisco	23
McCleave, T. C.,	Berkeley	1	McNelle, O. M.,	Los Angeles	10	Milo, H. W.,	Mountain View	28
McCleave, T. C., Jr.,	Oakland	1	McNulty, A. H.,	San Francisco	23	Milton, J. T.,	San Diego	22
McClelland, E. S.,	Los Angeles	10	McPharlin, J. H.,	Salinas	14	Minaker, A. J.,	San Francisco	23
McCleendon, S. J.,	San Diego	22	McPhee, V. C.,	San Francisco	23	*Miner, L. L.,	Los Angeles	10
McClure, G.,	Oakland	1	McPheeters, E. R.,	Modesto	34	Minna, J. B.,	San Diego	22
McClure, J. C.,	Lindsay	36	McPherson, M. D.,	Santa Cruz	29	Misch, H. B.,	Los Angeles	10
McClure, J. L.,	San Francisco	23	McQuade, J.,	San Francisco	23	Missall, A. S.,	Santa Maria	27
McClurkin, A. A.,	Los Angeles	10	McRae, C. C.,	San Francisco	23	Missner, F. R.,	Oakland	1
McColl, J. M.,	San Diego	22	McReynolds, M. C.,	Angwin	15	Mitchell, C. O.,	Fresno	4
McColl, W. F.,	San Diego	22	McReynolds, R. P.,	Los Angeles	10	Mitchell, H. H.,	Oakland	1
McCombs, V. J.,	Los Angeles	10	McWhirter, W. L.,	Centerville	1	Mitchell, W. E.,	Berkeley	1
McConnell, J. B.,	San Diego	22	McWhorter, P.,	Beverly Hills	10	Mizel, M. L.,	San Francisco	23
McConnell, O. G.,	San Jose	28	Mead, C. I.,	Bakersfield	7	Mizener, M.,	Southgate	10

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Mock, D. C., Redlands.....		21	Mudd, S. G., San Marino.....		10	Newton, E. B., Oakland.....		1
Modern, F. S., Los Angeles.....		10	Mueller, R. R., Los Angeles.....		10	Newton, H. D., San Diego.....		22
Moes, R. J., Los Angeles.....		10	Mugford, I. K., Sacramento.....		19	Newton, W. C., San Diego.....		22
Moffat, W. McK., Santa Barbara.....		27	Mugler, F. R., San Luis Obispo.....		25	Nicholas, C. Z., Santa Barbara.....		27
Moffitt, E. J., Los Angeles.....		10	Muhl, A. M., San Diego.....		22	Nichols, F. C., Santa Monica.....		10
Moffitt, H. C., San Francisco.....		23	Muir, J. C., San Jose.....		28	Nichols, J. N., Los Angeles.....		10
Moffitt, T. W., Hollywood.....		10	Mulder, E. I., Compton.....		10	Nichols, R. C., Ontario.....		21
Mogan, R. F., Los Angeles.....		10	Mulfinger, C. L., Los Angeles.....		10	Nichols, R. E., Woodland.....		38
Mohs, O. K., San Francisco.....		23	Mullaly, E. F., Vallejo.....		32	Nichols, W. E., Pasadena.....		10
Mohun, C. C., Jr., San Francisco.....		23	Mullen, E. W., Agnew.....		28	Nicholson, J., Los Angeles.....		10
Mohun, M., San Mateo.....		26	Mullen, J. L., Sacramento.....		19	Nicholson, J. McG., Bakersfield.....		7
Molgaard, J., San Francisco.....		26	Mullen, T. F., San Francisco.....		23	Nicholson, J. W., Porterville.....		36
Molitor, N., San Diego.....		22	Mulligan, H. R., Hollywood.....		10	Nicholson, R. M., Los Angeles.....		10
Mollath, A. L., Guadalupe.....		27	Mulvehill, W., Los Angeles.....		10	Nider, G. K., Fresno.....		4
Molony, W. R., Los Angeles.....		10	Mundall, E. P., Glendale.....		10	Niebel, H. L., Palo Alto.....		28
Molony, W. R., Jr., Los Angeles.....		10	Munter, E. J., San Francisco.....		23	Niebergall, H. A., Los Angeles.....		10
Monaco, S. R., Los Angeles.....		10	Murakami, K., Salinas.....		14	Nielsen, H. W., Fowler.....		4
Monson, L. P., San Francisco.....		23	Muramoto, J., Sacramento.....		19	Nielsen, J. C. E., San Diego.....		22
Montalvan, J., Oakland.....		1	Murphy, H. C., Salinas.....		14	Nielsen, J. M., Los Angeles.....		10
Monteith, R. F., Redwood City.....		26	Murphy, J. B., San Mateo.....		26	Nielsen, J. W., Oxnard.....		37
Montgomery, C. H., Los Angeles.....		10	Murphy, J. E., Sacramento.....		19	Nielson, L. R., Fresno.....		4
Montgomery, D. W., San Francisco.....		23	Murphy, P. J., Los Angeles.....		26	Niemand, F. G., San Francisco.....		23
Montgomery, J. L., Mandovi, Wis.....		10	Murphy, W. H., San Mateo.....		10	Nies, A., Orange.....		16
Montgomery, M. F., San Francisco.....		23	Murray, D. H., Napa.....		15	Nies, C. A., Los Angeles.....		10
Montgomery, M. L., San Francisco.....		23	Murray, S., Los Angeles.....		10	Nilsson, J. P., Long Beach.....		10
Montgomery, R. R., Long Beach.....		23	Murrieta, A. J., Los Angeles.....		10	Nippert, E. F., Los Angeles.....		10
Montgomery, W. O., San Francisco.....		23	Musante, A. S., San Francisco.....		23	Nisbet, T. W., Pasadena.....		29
Monty, A. J., San Jose.....		28	Musselman, W. H., South San Francisco.....		26	Nittler, A. N., Santa Cruz.....		29
Moodle, A. R., Taft.....		7	Musser, L. P., Oakland.....		26	Nixon, A. C., Hollywood.....		10
Moody, A. M., San Francisco.....		23	Myers, A. D., Phoenix, Arizona.....		21	Nixon, N. K., Los Angeles.....		10
Moody, E. E., Los Angeles.....		10	Myers, C., Los Angeles.....		10	Noall, E. T., Santa Rosa.....		33
Mooney, H. S., Los Angeles.....		10	Myers, G. E., Los Angeles.....		10	Noble, B. E., Los Angeles.....		10
Moor, F. B., Loma Linda.....		21	Myers, L., San Diego.....		22	Noble, C. A., Jr., San Francisco.....		23
Moore, A. H., Los Angeles.....		10	Myers, O. R., Eureka.....		5	Noble, T. E., Long Beach.....		10
Moore, A. W., Los Angeles.....		10	Myers, T. C., Los Angeles.....		10	Noetling, P. R., Angels Camp.....		24
Moore, C. B., San Francisco.....		23	Mythaler, E. L., Groveland.....		13	*Nogge, G. E., Chino.....		21
Moore, C. E., San Jose.....		28				Nolan, O. F., San Francisco.....		23
Moore, C. L., Bakersfield.....		7				Nolan, T. J., San Francisco.....		23
Moore, E. C., Los Angeles.....		10				Noland, C. A., Long Beach.....		10
Moore, G., Oakland.....		1				Norman, G. F., Eureka.....		5
Moore, G. W., Los Angeles.....		10				Norman, J. G., San Pedro.....		10
Moore, H. A., Berkeley.....		1				Norris, C. E., Eureka.....		5
Moore, J. B., Fresno.....		4				Norris, W. J., Los Angeles.....		10
Moore, J. K., Los Angeles.....		10				Northrop, R. S., Napa.....		15
Moore, L., San Francisco.....		23				Northway, W. H., Stanford Univ.....		28
Moore, L. S., San Jose.....		28				Norton, F. L., Los Angeles.....		10
Moore, M. H., Fresno.....		4				Norwood, G. E., Covina.....		10
Moore, N. L., Santa Ana.....		16				Novy, F. G., Oakland.....		1
Moore, O. M., Bell.....		10				Noyes, F. Le G., Los Angeles.....		10
Moore, P. H., Hollywood.....		10				Nuttall, J. P., Santa Monica.....		10
Moore, R., Los Angeles.....		10				Nutting, F. J., Santa Monica.....		10
* Moore, T. V., San Jose.....		28				Nutting, R. J., Oakland.....		1
Moore, W. G., San Francisco.....		23				Nuzum, F. R., Santa Barbara.....		27
Moore, W. H., Bakersfield.....		7						
Moore, R. M., San Bernardino.....		21						
Moreland, J. W., Eureka, Nevada.....		21						
Morgan, J. D., Jr., Fresno.....		4						
Morgan, J. W., San Francisco.....		23						
Morgan, M. D., San Francisco.....		23						
Morris, B. G., Indio.....		18						
Morris, C. A., Bakersfield.....		7						
Morris, E., Auberry.....		4						
Morris, F. J., Los Angeles.....		10						
Morris, G. H., Santa Maria.....		27						
Morris, J. K., Jr., Modesto.....		34						
Morris, K. G., Petaluma.....		33						
Morris, L. M., San Francisco.....		23						
Morris, M., San Francisco.....		23						
Morris, R. L., San Francisco.....		23						
Morrison, A. A., Santa Paula.....		37						
Morrison, L. F., San Francisco.....		23						
Morrison, N. D., San Mateo.....		26						
Morrison, R. J., Santa Monica.....		10						
Morrison, W. A., Los Angeles.....		10						
Morrissey, E. J., San Francisco.....		23						
Morrow, A., Richmond.....		3						
Morrow, H., San Francisco.....		23						
Morse, C. O., Redwood City.....		26						
Morse, H. A., Oakland.....		1						
Mortensen, E. S., Santa Monica.....		10						
Mortensen, J. P., Los Angeles.....		10						
Mortensen, W. L., Culver City.....		10						
Mortensen, W. S., Santa Monica.....		10						
Morton, A. W., San Francisco.....		23						
Morton, D. G., San Francisco.....		23						
Morton, L. B., Los Angeles.....		10						
Mosby, G., Oakland.....		1						
Mosher, W. F., Ventura.....		37						
Mote, C. D., San Francisco.....		23						
Motley, E. G., Santa Ana.....		16						
Mott, E. L., Fresno.....		4						
Mottram, L. D., Modesto.....		34						
Moulton, D. H., Chico.....		2						
Moulton, R. R., San Mateo.....		26						
Mountford, G. T., Coalinga.....		4						
Mourer, L. A., Los Angeles.....		10						
Movlitt, S. I., Los Angeles.....		10						
Movius, C. McK., Los Angeles.....		10						
Movius, H. J., Los Angeles.....		10						
Moyle, C. A., Merced.....		13						
Muckleston, H. S., Los Angeles.....		10						
Mudd, J. L., Merced.....		13						

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Olson, G. W.,	Fullerton	16	Patton, E. F.,	Los Angeles	10	Plymire, D. B.,	San Francisco	23
Omelvena, J. G.,	San Diego	22	Paul, S. B.,	San Francisco	23	Poage, C. A.,	Colusa	38
O'Neill, A. A.,	San Francisco	23	Paul, R. A.,	La Jolla	22	Podstata, V. H.,	San Francisco	1
O'Neill, F. H.,	Eureka	5	Paup, M. K.,	Needles	21	Poheim, J. F.,	San Francisco	23
O'Neill, B. J., Jr.,	San Diego	22	Paxman, D. G.,	Oakland	1	Polesky, F. A.,	Los Angeles	10
O'Neill, J. N.,	Los Angeles	10	Paxson, J. T.,	Berkeley	1	Poley, C. W.,	Los Angeles	10
O'Neill, T. J.,	Los Angeles	10	Payton, W. B.,	Riverside	18	Polland, W. S.,	San Rafael	11
Onesti, S. J.,	San Francisco	23	Pchelkin, N. A.,	San Francisco	23	Polia, J. A.,	Los Angeles	10
Orbison, T. J.,	Los Angeles	10	Pearce, C. M.,	Oakland	1	Pollock, W. E.,	Sacramento	19
Orcutt, A. H.,	Oakland	1	Pearce, W. M.,	Wilmington	10	Pomeroy, F. K.,	Fresno	4
Orella, F. R.,	San Francisco	23	Pearl, F. A.,	Los Angeles	10	Pomeroy, G. T.,	Yountville	15
Ormsby, E. A.,	Centerville	1	Pearl, F. L.,	San Francisco	23	Pomeroy, J. L.,	Los Angeles	10
Orr, J.,	Oakland	1	Pearson, B. S.,	Los Angeles	10	Pond, S. B.,	Patton	21
Orth, G. L.,	Redding	30	Pearson, C. E.,	Turlock	34	Poole, F. H.,	Santa Cruz	29
Osborn, H. B.,	Fillmore	37	Pearson, E. A.,	Los Angeles	10	Pope, W. H.,	Sacramento	19
Osborne, C. J.,	San Diego	22	Pearson, R. G.,	Sacramento	19	Popkin, R. J.,	Los Angeles	10
Osborne, R. H.,	Los Angeles	10	Peck, J. W.,	Berkeley	1	Port, W. W.,	San Francisco	23
Osburn, J. N. N.,	Los Angeles	10	Peddicoor, H.,	Redwood City	26	Porter, C. D.,	San Francisco	23
Ostroff, R. A.,	San Francisco	23	Peers, R. A.,	Colfax	17	Porter, E. E.,	San Jose	28
Otis, E. F.,	Brea	16	Peers, R. S.,	Oakland	1	Porter, E. B.,	Altadena	22
Otis, M. R.,	Los Angeles	10	Peery, J. T.,	Corcoran	8	Porter, G. S.,	Los Angeles	10
Otis, N. M.,	Santa Monica	10	Peery, L. T.,	Berkeley	1	Porter, J. A.,	Modesto	34
Ott, E. R.,	Carmel	1	Peisols, E. C.,	Claremont	10	Porter, J. I.,	Benicia	32
Ottenger, M. R.,	San Francisco	23	Pelkan, K. F.,	San Jose	28	Porter, M. E.,	Eldridge	33
Otto, F. W.,	Los Angeles	10	Peluso, J. D.,	Los Angeles	10	Porter, R. L.,	San Francisco	23
Oviedo, G. F.,	San Francisco	23	Pendergrass, C. I.,	Clovis	4	Porter, W. S.,	Oakland	1
Owen, C. C.,	San Bernardino	21	Pendergrass, J. E.,	Clovis	4	Post, J. O.,	Los Angeles	10
Owen, C. S.,	National City	22	Pendleton, W. C.,	Los Angeles	10	Poston, H. P.,	Pasadena	10
Owen, E. D.,	San Francisco	23	Pendleton, W. R.,	Long Beach	10	Pottenger, F. M.,	Monrovia	10
Owen, G. R.,	Los Angeles	10	Penn, H. S.,	Los Angeles	10	Pottenger, F. M., Jr.,	Monrovia	10
Owens, R. L.,	Lodi	24	Penn, L. L.,	San Francisco	23	Pottenger, J. E.,	Monrovia	10
Owens, W. R.,	Glendale	10	Pennington, A. S.,	San Francisco	23	Pottenger, R. T.,	Pasadena	10
Oyler, J. D.,	Los Angeles	10	Peoples, S. Z.,	Petaluma	33	Potter, A.,	San Francisco	23
— P —			Peppers, C. H.,	Los Angeles	10	Potter, C. D.,	San Francisco	23
Paap, G. F.,	Long Beach	10	Percy, J. F.,	Los Angeles	10	Potter, G.,	Oakland	1
Pace, P. T.,	San Jose	28	Perkins, H. B.,	Vallejo	32	Potter, H. G.,	Winters	38
Packard, L. A.,	Bakersfield	7	Perkins, W. A.,	Oakland	1	Potter, M. J. M.,	San Diego	22
Padden, E. H.,	Alameda	1	Perry, C. G.,	Sausalito	11	Potter, W. H.,	San Diego	22
Padgett, V. W.,	Alleghany	17	Perry, I. H.,	San Francisco	23	Pouppirt, P. S.,	San Francisco	23
Paez, J.,	San Diego	22	Perry, J. R.,	West Hollywood	10	Powell, A.,	Lafayette	1
Page, B. H.,	San Mateo	26	Perry, O. H.,	Yuba City	39	Powell, B. J.,	Stockton	24
Page, C. W.,	Berkeley	1	Perzik, S. L.,	Los Angeles	10	Powell, B. J., Jr.,	Stockton	24
Page, W. E.,	Oakland	1	Petch, P. H.,	Oakland	1	Powell, D. R.,	Stockton	24
Pahl, P. C. H.,	Los Angeles	10	Peters, C.,	San Francisco	23	Powell, R. C.,	Richmond	3
Paige, G. A.,	Anaheim	16	Peters, C. E.,	Oakland	1	Powell, T. O.,	Los Angeles	10
Paine, N. C.,	Glendale	10	Peters, L.,	Alameda	1	Powell, W. A.,	Martinez	3
Palamountain, W. B.,	Oakland	1	Petersen, H. C.,	Stockton	24	Powers, A. R.,	Tracy	24
Pallais, A.,	Los Angeles	10	Petersen, H. E.,	San Fernando	10	Powers, E. S.,	Los Angeles	10
Pallesen, V. W.,	Walnut Grove	19	Petersen, A. A.,	Los Angeles	10	Powers, R. A.,	Palo Alto	28
Palette, E. C.,	Los Angeles	10	Petersen, A. A.,	Los Angeles	10	Pratt, B. H.,	Lemoore	8
Pallette, E. M.,	Los Angeles	10	Petersen, E. A.,	Vallejo	6	Pratt, E. D.,	Burbank	10
Palmer, B. M.,	Oakland	1	Petersen, F. W.,	El Centro	32	Pratt, M. D.,	Fall River Mills	30
Palmer, C. B.,	San Francisco	23	Peterson, J. B.,	Los Angeles	10	Pratt, O. B.,	Los Angeles	10
Palmer, E. O.,	Hollywood	10	Peterson, L. J.,	Lodi	24	Premo, M. A.,	San Jose	28
Palmer, R. S.,	Pomona	10	Petr, F.,	Turlock	34	Presnell, J. F.,	Los Angeles	10
Palmer, W. B.,	Long Beach	10	Petter, R. S.,	Los Angeles	10	Pressley, J. F.,	San Francisco	23
Palomeque, E. J.,	Tampico Tampa, Mexico	22	Pettis, J. H.,	Fresno	4	Pressman, J. J.,	Los Angeles	10
Paretzky, M.,	Los Angeles	10	Pettit, A. V.,	San Francisco	23	Preston, A. W.,	Visalia	36
Parizek, F. J.,	Los Angeles	10	Pettler, S. H.,	Los Angeles	10	Preuss, C. A.,	Santa Barbara	27
Park, D. B.,	Vallejo	32	Petty, C. O.,	Fullerton	16	Price, L. G.,	Fresno	4
Parker, A. S.,	Merced	13	Pfeiffer, H. W.,	La Mesa	22	Prien, R. H.,	Gilroy	28
Parker, C. H.,	Pasadena	10	Pfueger, O. H.,	San Francisco	23	Priestley, S. F.,	Stockton	24
Parker, G.,	Salinas	14	Phelan, C. A.,	San Francisco	23	Prigge, E. K.,	Los Angeles	10
Parker, H. R.,	Oakland	1	Phelps, P. S.,	New Bedford, Conn.	17	Primasing, R.,	Courtland	19
Parker, J. A.,	Merced	13	Phetteplace, D. O.,	Fullerton	16	Prince, L. D.,	San Francisco	23
Parker, J. A.,	Los Angeles	10	Phillips, A. D.,	Sacramento	19	Prince, P. W.,	Long Beach	10
Parker, J. L.,	Brawley	6	Phillips, A. L.,	Santa Cruz	29	Prince, R. W.,	San Bernardino	21
Parker, J. T.,	Oakland	1	Phillips, C. E.,	Los Angeles	10	Prindle, K. H.,	San Mateo	26
Parker, L. O.,	San Francisco	23	Phillips, L.,	Hollywood	10	Prisinzano, G.,	Sacramento	19
Parker, T. A.,	La Jolla	22	Phillips, L. F. E.,	Palo Alto	28	Pritchard, F. H.,	Colton	21
Parker, W. B.,	Los Angeles	10	Philp, W. S.,	Los Angeles	10	Pritchard, J. L.,	San Jose	28
Parkin, V.,	Los Angeles	10	Pickard, R. J.,	San Diego	22	Pritchard, W. F.,	San Bernardino	21
Parkinson, R. H.,	San Francisco	23	Pidcock, J. W.,	Hollywood	1	Proctor, D. T.,	Los Angeles	10
Parkinson, S. N.,	Oakland	1	Pier, H. McK.,	Oakland	1	Proescher, F.,	San Jose	28
Parkinson, S. R.,	Marysville	39	Pierce, G. W.,	San Francisco	23	Profant, H. J.,	Santa Barbara	27
Parkinson, W. B.,	Tulare	36	Pierce, H. F.,	Santa Barbara	27	Proffoot, C. P.,	San Luis Obispo	25
Parks, B. K.,	Long Beach	10	Pierce, S. N.,	Los Angeles	10	Pruett, H. J.,	San Francisco	23
Parks, F. R.,	Los Angeles	10	Pierion, P. H.,	San Francisco	23	Pruett, J. F.,	San Francisco	23
Parks, K. G.,	Anaheim	16	Pillsbury, S. G.,	Long Beach	13	Pryor, H. B.,	Palo Alto	28
Parowski, S. A.,	San Diego	22	Pimentel, G. B.,	Los Banos	13	Pulford, D. S.,	Sacramento	19
Parrish, C. R.,	Los Angeles	10	Pindell, M. L.,	Los Angeles	10	Purcell, R.,	Los Angeles	10
Parrish, G.,	Los Angeles	10	Pindler, L. A.,	Los Angeles	10	Purdy, A. P.,	San Francisco	23
Parrott, J. C.,	San Francisco	23	Pinness, G.,	Los Angeles	10	Purley, G. P.,	Arcata	5
Parsons, H. H.,	Anniston, Alabama	21	Pinkerton, C. G.,	Los Angeles	10	Pursell, F. J.,	Los Angeles	10
Parsons, S. R.,	Santa Barbara	27	Pinkham, C. B.,	San Francisco	23	Purvlance, C. C.,	Fairfield	32
Partch, W. T.,	Oakland	1	Pinkley, V. M.,	San Bernardino	21	Putnam, H. A.,	Monrovia	10
Pasette, S. E.,	Los Angeles	10	Pinney, I.,	Stockton	24	Putnam, V.,	San Francisco	23
Pate, W. H.,	Alturas	9	Pinto, H. E.,	Agnon	12	— Q —		
Pafeck, S. D.,	San Francisco	23	Piper, H. E.,	Santa Cruz	29	Quaintance, P. A.,	Los Angeles	10
Pateron, F. H.,	Santa Ana	16	Pischel, D. K.,	San Francisco	23	Quarry, P. T.,	Santa Rosa	33
Patrick, M. A.,	Los Angeles	10	Pischel, K.,	San Francisco	23	Quigley, J. S.,	Oakland	1
Patterson, E. A.,	Dos Palos	13	Piscitelli, A. M.,	San Francisco	23	Quimby, S. A.,	Madera	4
Patterson, G. H.,	Los Angeles	10	Pitkin, H. C.,	San Francisco	23	Quinan, C.,	Nevada City	17
Patterson, G. L.,	Santa Rosa	33	Pitts, E. H.,	Sacramento	19	Quinlan, C. M.,	Santa Rosa	33
Patterson, J. A.,	San Bernardino	21	Plus, C.,	Yreka	31	Quinlan, J. F.,	San Francisco	23
Patterson, J. K.,	Santa Barbara	27	Plane, J. F.,	Long Beach	10	Quinn, E. M.,	Vallejo	32
			Plank, T. H.,	San Francisco	23	Quinn, T. D. A.,	San Francisco	23
			Plath, H. W.,	Oakland	1			
			Platt, J. E.,	Pasadena	10			
			Player, L. P.,	San Francisco	23			
			Pleth, V.,	Santa Rosa	33			
			Plimpton, E. B.,	Los Angeles	10			

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Quinn, V. J., Los Angeles.....		10	Reische, A. E., Oakland.....		1	Rogers, W. L., San Francisco.....		23
Quinn, W. F., Los Angeles.....		10	Reiss, O., Los Angeles.....		10	Rohlfes, B. J., San Francisco.....		23
Quinn, W. J., Eureka.....		5	Reiss, T. H., Alameda.....		1	Rohrbacher, G. H., Stockton.....		24
Quirnbach, R. P., Spadra.....		23	Reitzel, R. J., San Mateo.....		26	Rolland, W. M., Los Angeles.....		10
- R -			Remaly, C. E., Los Angeles.....		10	Roller, C. S., Woodland.....		38
Rabinowitz, R., San Francisco.....		23	Remington, L. D., Monrovia.....		10	Rolph, W. D., National City.....		22
Rabwin, M. H., Los Angeles.....		10	Rommel, A. J., San Francisco.....		23	Roncoveri, L., San Francisco.....		23
Racer, F. H., Lomita.....		10	Remmen, E. T., Glendale.....		10	Rood, R. S., Davenport.....		29
Rachmel, W., Los Angeles.....		10	Renner, J. H., Santa Barbara.....		27	Rood, V. V., Grass Valley.....		17
Radford, E. B., Walnut Creek.....		3	Replogle, E. G., Los Angeles.....		10	Rook, C. W., Montrose.....		27
Ragan, S. T., Los Angeles.....		10	Ress, I. LeR., Los Angeles.....		10	Roome, C. T., Santa Barbara.....		10
Railsback, O. C., Woodland.....		38	Rethwilm, L. A., San Francisco.....		23	Rooney, C. E., Santa Monica.....		10
Raitt, G. E., Santa Ana.....		16	Reud, W. R., Oakland.....		1	Rooney, H. M., Los Angeles.....		10
Rajotte, E. C. F., San Francisco.....		23	Rey, H. F., Oxnard.....		37	Roos, A. R., Loma Linda.....		21
Rambo, W. H., Los Angeles.....		10	Reyes, J. M. de l., Los Angeles.....		10	Roos, D. D., Corona.....		18
Rammelt, W., Los Angeles.....		10	Reynolds, C. E., Glendale.....		10	Root, P. N., Bakersfield.....		7
Ramsay, R. E., Pasadena.....		10	Reynolds, F. C., Chico.....		2	Root, R. R., Corona.....		18
Rand, C. W., Los Angeles.....		10	Reynolds, H. C., Arlington.....		18	Rosanoff, A. J., Los Angeles.....		10
Randall, D. T., Southgate.....		10	Reynolds, J., Los Angeles.....		10	Rosasco, J. L., Stockton.....		24
Randall, S. B., Santa Cruz.....		29	Reynolds, J. M., Long Beach.....		10	Rosasco, O. L., Saratoga.....		28
Randel, H. A., Fresno.....		4	Reynolds, L. G., Los Angeles.....		10	Rosburg, A. H., San Francisco.....		23
Raney, R. B., Los Angeles.....		10	Reynolds, L. R., San Francisco.....		23	Roscoe, A. M., Newman.....		34
Ranker, E. R., Oakland.....		1	Reynolds, P. A., Los Angeles.....		10	Rose, C. M., Los Angeles.....		10
Rankin, A. H., San Francisco.....		23	Reynolds, R. A., San Francisco.....		23	Rose, H. de W., Sonora.....		24
Rankin, E. P., Berkeley.....		1	Reynolds, T. E., Oakland.....		1	Rose, J. T., Healdsburg.....		33
Rankin, T. J., San Diego.....		22	Rhind, R., Hermosa Beach.....		10	Rose, L. M., Santa Clara.....		28
Ransom, D. H., Madera.....		4	Rhodes, G. K., San Francisco.....		23	Rosenberg, M. N., Sawtelle.....		10
Ransom, J. K., Modesto.....		34	Rhone, T. B., Orange.....		16	Rosenberg, M. W., Los Angeles.....		10
Ranson, J. R., San Luis Obispo.....		25	Rhymes, L. H., Canoga Park.....		10	Rosenberger, H. G., Whittier.....		10
Rapaport, H., Los Angeles.....		10	Riach, M. T., San Diego.....		22	Rosenblatt, J., Duarte.....		10
Rapaport, W., Imola.....		15	Rice, C. H., Oakland.....		1	Rosenblum, D. H., Los Angeles.....		10
Raphael, J. C., Oakland.....		1	Rice, F. M., San Francisco.....		23	Rosenblum, H. H., San Francisco.....		23
Rasor, C., Oakland.....		1	Richards, C. M., San Jose.....		28	Rosencrantz, E., San Francisco.....		23
Rathbone, R. H., Los Angeles.....		10	Richards, D. N., Oakland.....		1	Rosenfeld, M. H., Los Angeles.....		10
*Rathbun, W. T., Colusa.....		38	Richards, S. B., San Bernardino.....		21	Rosenkranz, H. A., Los Angeles.....		10
Ratliff, H. L., Riverside.....		18	Richardson, G. C., Sonora.....		24	Rosenthal, A. G., San Francisco.....		23
Ratner, R., San Francisco.....		23	Richter, C., Balboa Beach.....		16	*Rosoff, J. A., Compton.....		10
Ratty, F. J., San Diego.....		22	Richter, I. M., Santa Barbara.....		27	Rosove, L., Santa Monica.....		10
Raulston, B. O., Los Angeles.....		10	Rickabaugh, H. B., Alhambra.....		10	Ross, A., Los Angeles.....		10
Ravenscroft, J. W., San Diego.....		22	Riddell, O. J., Alhambra.....		10	Ross, D. E., Los Angeles.....		10
Rawlins, A. G., San Francisco.....		23	*Rigdon, R. L., San Francisco.....		23	Ross, K. F., Los Angeles.....		10
Ray, E. B., Bellflower.....		10	Riggin, L. L., Pasadena.....		10	Ross, M. H., Los Angeles.....		10
Ray, F. S., Los Angeles.....		10	Righetti, E., San Francisco.....		23	Ross, P., Richmond.....		3
Ray, H. H., San Mateo.....		26	Righetti, H., San Francisco.....		23	Ross, S. G., Pasadena.....		10
Ray, L., Santa Rosa.....		33	Rinehart, J. F., San Francisco.....		23	Ross, V. R., Stockton.....		24
Raymond, A., San Francisco.....		23	Rinkenberger, F. W., Los Angeles.....		10	Rosson, C. T., Hanford.....		8
Rea, B. J., Sacramento.....		19	Rinne, F. A., San Francisco.....		23	Rosson, R. W., Tulare.....		36
Rea, R. R., Los Angeles.....		10	Risley, E. H., Loma Linda.....		21	Roth, A., Brooklyn, New York.....		10
Rea, S. L., Ukiah.....		12	Risser, J. C., Pasadena.....		10	Roth, E. F., Palo Alto.....		28
Rea, T., Yreka.....		31	Rivin, H. A., Delano.....		7	Roth, G. H., Los Angeles.....		10
Read, F. T., Glendale.....		10	Rixford, E., San Francisco.....		23	Roth, H. A., Long Beach.....		10
Read, J. M., San Francisco.....		23	Rixford, E. L., Jr., San Francisco.....		23	Rothman, P. E., Los Angeles.....		10
Ready, F. L., Los Angeles.....		10	Rixford, H. C., Stockton.....		24	*Rothschild, M., San Francisco.....		23
Ream, M. P., San Leandro.....		1	*Roath, C., Los Angeles.....		10	Rothwell, W. T., Los Angeles.....		10
Reamer, E. F., Modesto.....		34	Roath, C. A., Jr., Los Angeles.....		10	Rouff, E., San Jose.....		28
Reardon, F. B., Sacramento.....		19	Robarts, H. P., San Francisco.....		23	Rouse, D. E., San Fernando.....		10
Reasner, W. F., Santa Monica.....		19	Robbins, A. C., Garden Grove.....		16	Rover, H. P., Los Angeles.....		10
Rebec, W. G., Belmont.....		26	Robbins, A. R., Los Angeles.....		10	Rowan, E. J., Wilmington.....		10
Reckers, W. A., Placerville.....		19	Robbins, B., Hanford.....		8	Rowe, A. H., Oakland.....		1
Rector, J. M., San Francisco.....		23	Robbins, D. R., Los Angeles.....		10	Rowe, M. J., Norwalk.....		10
Redelings, L. H., San Diego.....		22	Roberg, D. N., San Jose.....		28	Rowell, H. N., Berkeley.....		1
Redewill, F. H., San Francisco.....		23	Roberts, A. M., Los Angeles.....		10	Rowell, W. A., Trinity Center.....		3
Redmond, M. H., Huntington Park.....		10	Roberts, E. K., Los Angeles.....		10	Royer, J. E., Oakland.....		1
Reed, A. C., San Francisco.....		23	Roberts, G. J., Pomona.....		10	Royston, E. A., Los Angeles.....		10
Reed, C. C., Compton.....		10	Roberts, G. W., Oakland.....		1	Rubenstein, C. L., San Francisco.....		23
Reed, E. N., Santa Monica.....		10	Roberts, J. G., Pomona.....		10	Rubin, J. S., Los Angeles.....		10
Reed, J. R., Pasadena.....		10	Roberts, J. M., Los Angeles.....		10	Rubinstein, I., Los Angeles.....		10
Reed, W. J., Los Angeles.....		21	Roberts, W. H., Pasadena.....		10	Ruddock, J. C., Los Angeles.....		10
Reed, W. W., Nevada City.....		17	Robertson, D. L., Modesto.....		34	Ruddy, L. W., Sacramento.....		19
Reeder, C. W., Long Beach.....		10	Robertson, G., San Francisco.....		23	Rude, A. E., Los Angeles.....		10
Reekie, K. E., San Jacinto.....		18	Robertson, H. R., Los Angeles.....		10	Rue, H. A., Los Angeles.....		10
Reeng, J. D., San Francisco.....		23	Robertson, J. C., Modesto.....		34	Ruediger, E. H., San Diego.....		22
Rees, C. E., San Diego.....		22	Robertson, J. W., Jr., Livermore.....		1	Rueter, K., Oakland.....		1
Rees, C. W., San Diego.....		22	Robertson, R. R., San Rafael.....		11	Ruff, F. R., Fresno.....		4
Rees, D. M., Monterey Park.....		10	Robinson, J., Anaheim.....		16	Ruggles, H. E., San Francisco.....		23
Rees, H. C., Los Angeles.....		10	Robinson, J. H., Los Angeles.....		10	Rukke, G. V., Monterey.....		14
Rees, R. B., Bakersfield.....		7	Robinson, J. M., San Francisco.....		23	Rulison, E. T., Sacramento.....		19
Reeves, E. W., Salinas.....		14	Robinson, J. W., Los Angeles.....		10	Rumph, P. E., Orange.....		16
Reeves, J. M., Oakland.....		1	Robinson, L. L., San Rafael.....		11	Runkel, G. H., McCloud.....		31
Reeves, J. W., Los Angeles.....		10	Robinson, S. P., Santa Barbara.....		27	Runner, J. F., San Francisco.....		23
Reeves, W. R., Salinas.....		14	Robinson, S. S., Los Angeles.....		10	Runyon, L. A., Sacramento.....		19
Regan, L. J., Los Angeles.....		10	Robison, L. H., Los Angeles.....		10	Rupp, J. J., Santa Barbara.....		27
Reich, A. Jr., San Francisco.....		28	Roblee, W. W., Riverside.....		18	Rusche, C. F., Hollywood.....		10
Reich, W. W., Berkeley.....		1	Rochex, F. J., San Francisco.....		23	Rush, R. C., San Fernando.....		10
Reiche, C., Los Angeles.....		10	Rodenbaugh, F. H., San Francisco.....		23	Russell, E. L., Santa Ana.....		16
Reichert, F. L., San Francisco.....		23	Rodin, F. H., San Francisco.....		23	Russell, F. C., San Diego.....		22
Reichle, P. A., Los Angeles.....		10	Roen, P. B., Hollywood.....		10	Russell, J. A., Auburn.....		17
Reid, R. B., Beaumont.....		18	Roger, J. H. D., San Francisco.....		23	Russell, J. P., Menlo Park.....		26
Reid, R. S., Oceanside.....		22	Rogers, A. M., Los Angeles.....		10	Russell, R., Glendale.....		10
Reilly, P. H., Vallejo.....		32	Rogers, E. L., Loma Linda.....		21	Russell, W. W., San Diego.....		22
Reilly, W., San Francisco.....		23	Rogers, H., Oakland.....		1	Ruth, E. S., Hollywood.....		10
Reilly, W. A., San Francisco.....		23	Rogers, H. S., Petaluma.....		33	Rutherford, F. de P., Santa Clara.....		28
Reina, S., Los Angeles.....		10	Rogers, J. A., San Francisco.....		23	Ryan, A. F., Los Angeles.....		10
Reinard, E., Los Angeles.....		10	Rogers, J. B., Imola.....		15	Ryan, A. J., Vallejo.....		32
Reinertsen, B. R., Los Angeles.....		10	Rogers, J. B., Los Angeles.....		10	Ryan, A. M., San Francisco.....		23
Reinle, G. G., Oakland.....		1	Rogers, J. D., Los Angeles.....		10	Ryan, C. D., Beverly Hills.....		10
Reis, A. G. DeS., Oakland.....		1	Rogers, L. B., Los Angeles.....		10	Ryan, F. S., San Jose.....		28
			Rogers, L. E., Los Angeles.....		10	Ryan, R. C., San Francisco.....		23
			Rogers, S., Tulare.....		36	Ryan, W. J., San Diego.....		22
			Rogers, T. J., Los Angeles.....		10	Ryder, B. E., Los Angeles.....		10
			Rogers, T. L., Long Beach.....		10	Rypins, R. F., San Francisco.....		23
			Rogers, W. G., Los Angeles.....		10	Rytand, D. A., San Francisco.....		23

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
- S -								
Saam, J. G., <i>Oakland</i>		1	Schuetz, C. E., <i>Hollywood</i>		10	Sher, B. H., <i>Los Angeles</i>		10
Sabich, G. C., <i>Claremont</i>		10	Schultz, C. E., <i>Castroville</i>		14	Sheranian, H. N., <i>Los Angeles</i>		10
Saeltzer, D. V., <i>Sacramento</i>		19	Schultz, H. H., <i>San Francisco</i>		23	Sherman, B. H., <i>Hollywood</i>		10
Safarik, E. S., <i>Los Angeles</i>		10	Schultz, L. O., <i>Glendale</i>		10	Sherman, J., <i>San Francisco</i>		23
Saffro, L. B., <i>San Pedro</i>		10	Schulz, R. L., <i>Los Angeles</i>		10	Sherman, R. S., <i>San Francisco</i>		23
Safer, M. H., <i>Palo Alto</i>		28	Schulze, M., <i>San Francisco</i>		23	Sherrard, E. E., <i>Los Angeles</i>		10
Sale, J. J., <i>San Francisco</i>		23	Schumacher, I. C., <i>San Francisco</i>		23	Sherrick, J. W., <i>Oakland</i>		1
Salisbury, C. S., <i>Los Angeles</i>		20	Schurmeier, H. L., <i>Santa Barbara</i>		27	Sherrill, J. W., <i>La Jolla</i>		22
Salomon, E., <i>San Francisco</i>		23	Schussler, H., Jr., <i>San Francisco</i>		23	Sherry, L. B., <i>Pasadena</i>		10
Salter, N. M., <i>Williams</i>		38	Schwalenberg, H. R., <i>Santa Barbara</i>		27	Shidler, G. P., <i>Torrance</i>		10
Sample, T. N., <i>Fresno</i>		4	Schwartz, A. H., <i>Los Angeles</i>		10	Shields, L., <i>Oakland</i>		1
Sampson, J. A., <i>Los Angeles</i>		10	Schwartz, D. Z., <i>Los Angeles</i>		10	Shiels, G. F., <i>Redwood City</i>		26
Sampson, J. J., <i>San Francisco</i>		23	Schwartz, F. L., <i>San Diego</i>		22	Shilling, J. W., <i>Los Angeles</i>		10
Sampson, J. P., <i>Santa Monica</i>		10	Schwartz, I., <i>San Francisco</i>		23	Shimkin, L., <i>San Francisco</i>		23
Sampson, M. H., <i>Berkeley</i>		1	Schwarz, I., <i>San Francisco</i>		23	Shimley, R. E., <i>Los Angeles</i>		10
Sampson, P. M., <i>Long Beach</i>		10	Schwarz, T. E., <i>Oakland</i>		1	Shipley, W. C., <i>Santa Rosa</i>		33
Sampson, W. A., <i>San Francisco</i>		23	Schwuchow, W. B., <i>Los Angeles</i>		10	Shipman, S. J., <i>San Francisco</i>		23
Sanderson, G. H., <i>Stockton</i>		24	Sciaroni, G. H., <i>Fresno</i>		4	Shippey, R. H., <i>Long Beach</i>		10
Sandholt, J. P., <i>Monterey</i>		14	Scobee, J. E., <i>Los Angeles</i>		10	Shirey, C. W., <i>North Hollywood</i>		10
Sandie, J., <i>Los Angeles</i>		10	Scovins, W. H., <i>Los Angeles</i>		10	Shirk, F. M., <i>La Verne</i>		10
Sands, R. A., <i>Ocean Park</i>		10	Scott, A. J., Jr., <i>Los Angeles</i>		10	Shoemaker, H., <i>Los Angeles</i>		10
Sands, R. L., <i>Santa Monica</i>		10	Scott, F. L., <i>Los Angeles</i>		10	Shone, L. B., <i>San Francisco</i>		23
Sanford, H. E., <i>Montrose</i>		10	Scott, J. T., <i>San Diego</i>		22	Shook, F. M., <i>Oakland</i>		1
Sanford, J. R., <i>Pasadena</i>		10	Scott, R. R., <i>Selma</i>		4	Shore, F. A., <i>Ventura</i>		37
Sansum, W. D., <i>Santa Barbara</i>		27	Scott, W. E., <i>San Francisco</i>		23	Shortley, T. M., <i>Carpinteria</i>		27
Sappington, E. E., <i>San Francisco</i>		23	Scovel, R. B., <i>San Francisco</i>		23	Short, J. E., <i>Los Angeles</i>		10
Sargent, W. H., <i>Oakland</i>		1	Scribner, R. G., <i>Sacramento</i>		19	Shreck, J. A., <i>Redlands</i>		21
Sartori, H. J., <i>San Francisco</i>		23	Scroggy, J. Q. A., <i>Los Angeles</i>		10	Shryock, E. H., <i>Loma Linda</i>		21
Sasso, J. A., <i>Los Angeles</i>		23	Scudder, R., <i>Fort Bragg</i>		12	Shryock, A., <i>Loma Linda</i>		21
Sauer, F. J., <i>Los Angeles</i>		10	Scuderi, S. A., <i>Los Angeles</i>		10	Shuck, C. H., <i>Fresno</i>		4
Sauer, F. K., <i>Los Angeles</i>		10	Seabolt, G. C., <i>South Pasadena</i>		10	Shufelt, A. A., <i>San Jose</i>		28
Saunders, C. E., <i>San Jose</i>		28	Seals, P. W., <i>Los Angeles</i>		10	Shulman, L., <i>Los Angeles</i>		10
Savage, J. C., <i>Los Angeles</i>		10	Searls, H. H., <i>San Francisco</i>		23	Shultz, E. L., <i>Los Angeles</i>		10
Savage, P. M., <i>San Bernardino</i>		21	Seaver, H. C., <i>Los Angeles</i>		10	Shumaker, E. K., <i>Los Angeles</i>		10
Savage, P. M., Jr., <i>San Bernardino</i>		21	Seavey, M. A., <i>Sacramento</i>		19	Shumaker, P. W., <i>Los Angeles</i>		10
Savage, S. H., <i>Lancaster</i>		10	Seawell, J. W., <i>Healdsburg</i>		33	Shuman, J. W., <i>Los Angeles</i>		10
Savage, W. W., <i>San Bernardino</i>		21	Sebastian, C. F., <i>Los Angeles</i>		10	Shumate, C. A., <i>San Francisco</i>		23
Saverien, A. E., <i>Los Angeles</i>		10	Sedgwick, V. de M., <i>Long Beach</i>		10	Shumate, F. O., <i>San Francisco</i>		23
Saverien, H. L., <i>Fair Oaks</i>		19	Seeburt, E. M. P., <i>San Francisco</i>		23	Shumate, T. E., <i>San Francisco</i>		23
Sawyer, F. E., <i>Oakland</i>		1	Seech, S. G., <i>Los Angeles</i>		10	Shutes, M. H., <i>Oakland</i>		1
Sawyer, L., <i>San Francisco</i>		23	Seeley, L. J., <i>Redding</i>		31	Sicherman, K. L., <i>Los Angeles</i>		10
Saylin, G. J., <i>Los Angeles</i>		10	Segall, G., <i>Los Angeles</i>		10	Sides, H. E., <i>Huntington Park</i>		10
Saylin, J., <i>Venice</i>		10	Selberth, J., <i>Pixley</i>		36	Siefert, A. C., <i>Oakland</i>		1
Saylor, B. F., <i>Redding</i>		30	Seid, M. J., <i>San Francisco</i>		23	Siegel, L. E., <i>Beverly Hills</i>		10
Scamell, J. W., <i>Oakland</i>		1	Seiger, H. W., <i>Los Angeles</i>		21	Siegmund, F. W., <i>Los Angeles</i>		10
Scanlan, J. M., <i>Imola</i>		15	Seitz, R. P., <i>San Francisco</i>		23	Sigworth, D. C., <i>Long Beach</i>		10
Scanlon, W. G., <i>Pasadena</i>		10	Sekiyama, I., <i>Los Angeles</i>		10	Silverberg, M. H., <i>San Francisco</i>		23
Scarboro, E. R., <i>Fresno</i>		4	Seletz, R., <i>Los Angeles</i>		10	Silverman, D. J., <i>Los Angeles</i>		10
Scarborough, R. A., <i>San Francisco</i>		23	Seligman, L. J., <i>Los Angeles</i>		10	Silvia, C. A., <i>Gilroy</i>		28
Scatena, F. N., <i>Sacramento</i>		19	Sellery, A. C., <i>Long Beach</i>		10	Simms, J. S., <i>Bellflower</i>		10
Schaefer, J. W., <i>Los Angeles</i>		10	Sellery, C. M., <i>Los Angeles</i>		10	Simon, J., <i>Los Angeles</i>		10
Schaeffer, R. W., <i>Redondo Beach</i>		10	Sellew, P. K., <i>Los Angeles</i>		10	Simons, C. G., <i>No. Hollywood</i>		10
Schaller, W. F., <i>San Francisco</i>		23	Sellon, G. I., <i>Fullerton</i>		16	Simonds, P. E., <i>Riverside</i>		18
Schallig, D. W., <i>Sacramento</i>		19	Semenov, H., <i>Los Angeles</i>		10	Simpson, B. E., <i>San Francisco</i>		23
Schaper, E. A., <i>San Leandro</i>		7	Servin, C., <i>Los Angeles</i>		10	Simpson, B. R., <i>San Diego</i>		22
Schatz, M. M., <i>Fresno</i>		4	Settle, F. B., <i>Long Beach</i>		10	Sinclair, A. D., <i>San Francisco</i>		23
Schaupt, K. L., <i>San Francisco</i>		23	Setzler, G. B., <i>Los Angeles</i>		10	Singer, H., <i>Los Angeles</i>		10
Schefcik, J. F., <i>Los Angeles</i>		10	Sevenman, G. W., <i>San Mateo</i>		26	Singerman, I., <i>Los Angeles</i>		10
Scheier, R. B., <i>San Francisco</i>		23	Sevier, E., <i>Sacramento</i>		19	Sink, W. D., <i>Santa Maria</i>		27
Schell, J. P., <i>San Jose</i>		28	Sewall, E. C., <i>San Francisco</i>		23	Sippy, J. J., <i>Stockton</i>		24
Schenck, G. F., <i>Los Angeles</i>		10	Seymour, E. C., <i>Olive View</i>		10	Sirbu, A. B., <i>San Francisco</i>		23
Scherfee, J. F., <i>Los Angeles</i>		10	Shackford, B. C., <i>Long Beach</i>		10	Sisson, C. E., <i>Los Angeles</i>		22
Schiffbauer, H. E., <i>Los Angeles</i>		10	Shade, M. A., <i>Oakland</i>		1	Sisson, M., <i>Oakland</i>		1
Schiller, M. M., <i>Los Angeles</i>		10	Shafer, F. P., <i>Los Angeles</i>		10	Skaff, J. E., <i>San Francisco</i>		23
Schilling, W., <i>San Francisco</i>		23	Shaffer, C. J., <i>Huntington Park</i>		10	Skaletter, E. A., <i>Los Angeles</i>		10
Schlageter, H. J., <i>San Francisco</i>		23	Shafor, H. A., <i>Los Angeles</i>		10	Skeel, D. W., <i>Los Angeles</i>		10
Schlappi, J. C., <i>San Diego</i>		22	Shaghoian, A. H., <i>Daly City</i>		26	Skelton, L. W., <i>Pasadena</i>		10
Schlesinger, E. R., <i>Los Angeles</i>		10	Shahovitch, G. P., <i>Los Angeles</i>		10	Skillen, J., <i>Olive View</i>		10
Schlotthauer, H. L., <i>Tehachapi</i>		7	Shambaugh, N. F., <i>Long Beach</i>		10	Skilling, L. E., <i>Alameda</i>		1
Schlotthauer, M. Q., <i>Tehachapi</i>		7	Sharp, G. S., <i>Pasadena</i>		10	Slagerman, V. B., <i>Los Angeles</i>		10
Schluter, H. F., <i>Sacramento</i>		19	Sharp, J. C., <i>San Jose</i>		28	Slater, H. M., <i>Palo Alto</i>		28
Schmelz, C. J., <i>Guerneville</i>		33	Sharp, J. G., <i>San Francisco</i>		23	Slattery, J. W., <i>Mountain View</i>		28
Schmid, C. F., <i>Hermosa Beach</i>		10	Sharp, K. F., <i>Fresno</i>		4	Slaughter, H. C., <i>Los Angeles</i>		10
Schmidt, A. E., <i>San Francisco</i>		23	Sharp, R. G., <i>San Diego</i>		22	Slavich, J. F., <i>Oakland</i>		1
Schmidt, D. A., <i>Los Angeles</i>		10	Sharpe, O. A., <i>San Francisco</i>		26	Sleeper, K. R., <i>Los Angeles</i>		10
Schmidt, D. G., <i>San Quentin</i>		11	Sharpsteen, J. R., <i>Oakland</i>		1	Slemons, J. M., <i>Los Angeles</i>		10
Schmidt, E. J., <i>Fresno</i>		4	Shattinger, C., <i>Los Altos</i>		28	Sloan, L. E., <i>Inglewood</i>		10
Schmidt, F. M., <i>Los Angeles</i>		10	Shaul, E. M., <i>Palo Alto</i>		23	Sloan, O. J., <i>Glendale</i>		10
Schmidt, P. E., <i>Glendale</i>		10	Shaw, E. B., <i>San Francisco</i>		23	Sloane, L. O., <i>Los Angeles</i>		10
Schmitt, E. O. G., <i>San Jose</i>		28	Shaw, H. N., <i>Los Angeles</i>		10	Slocum, Y. K., <i>Tarzana</i>		10
Schmitt, H. H., <i>Gilroy</i>		28	Shaw, L. O., <i>Walnut Park</i>		10	Smale, G. A., <i>Los Angeles</i>		10
Schmitt, L. S., <i>San Francisco</i>		23	Shea, J. J., <i>San Diego</i>		22	Small, C. K., <i>Oakland</i>		1
Schmoelle, J. M., <i>Los Angeles</i>		10	Shea, T. T., <i>San Francisco</i>		23	Smallberg, H. E., <i>W. Hollywood</i>		10
Schneider, E. H., <i>Los Angeles</i>		10	Sheafe, E. V., <i>Oakland</i>		1	Smalley, R. B., <i>Willets</i>		12
Schneiders, R. A., <i>San Diego</i>		22	Sheehy, F. T., <i>San Francisco</i>		23	Smallwood, W. C., <i>Long Beach</i>		10
Schoff, C. E., <i>Sacramento</i>		19	Sheets, O. B., <i>Los Angeles</i>		10	Smart, E. P., <i>Murphy</i>		10
Schofield, R. O., <i>Sacramento</i>		17	Shelby, D. C., <i>Los Angeles</i>		10	Smalley, R. C., <i>Los Angeles</i>		10
Scholl, A. J., <i>Los Angeles</i>		10	Sheldon, E. A., <i>Bellflower</i>		10	Smiley, H. W., <i>Indio</i>		18
Scholtz, J. R., <i>Los Angeles</i>		10	Sheldon, E. C., <i>Hollister</i>		20	Smiley, K. E., <i>Los Angeles</i>		10
Scholtz, M., <i>Los Angeles</i>		10	Sheldon, E. F., <i>Los Angeles</i>		2	Smitgen, P. H., <i>Inglewood</i>		10
Scholz, A. M., <i>Los Angeles</i>		10	Sheldon, F. B., <i>Orange</i>		24	Smith, A. E., <i>Los Angeles</i>		10
Schomaker, T. P., <i>San Francisco</i>		23	Sheldon, R. F., <i>Long Beach</i>		10	Smith, A. M., <i>Oakland</i>		1
Schoonmaker, G. D., <i>San Francisco</i>		23	Sheller, W. O., <i>Long Beach</i>		10	Smith, A. S. J., <i>San Jose</i>		28
Schott, H. J., <i>Los Angeles</i>		10	Shelton, E. K., <i>Santa Barbara</i>		27	Smith, B., <i>Los Angeles</i>		10
Schottstaedt, W. E. R., <i>Fresno</i>		4	Shelton, G. C., <i>Los Angeles</i>		10	Smith, B. H., <i>Santa Monica</i>		10
Schreiber, L. W., <i>Santa Monica</i>		10	Shelton, V. G., <i>Hollywood</i>		10	Smith, B. H., <i>Huntington Park</i>		10
Schroeder, F. B., <i>San Diego</i>		22	Shenk, F. P., <i>Santa Cruz</i>		29	Smith, C. E., <i>San Francisco</i>		23
Schroer, W., <i>Orange</i>		16	Shepard, C. E., <i>Stanford University</i>		28	Smith, C. L., <i>Maywood</i>		10
			Shepard, W. P., <i>San Francisco</i>		23	Smith, C. R., <i>Los Angeles</i>		10
			Shepardson, H. C., <i>San Francisco</i>		23	Smith, D. A., <i>Oakland</i>		23
			Shepherd, J. H., <i>San Jose</i>		28	Smith, D. V., <i>Long Beach</i>		10
			Shepherd, H. L., <i>Los Angeles</i>		10	Smith, E. D., <i>Solvang</i>		27

COUNTY			COUNTY			COUNTY		
NAME	CITY	SOCIETY NO.	NAME	CITY	SOCIETY NO.	NAME	CITY	SOCIETY NO.
Smith, E. G.,	Oakland.....	1	Spitalny, A.,	San Francisco.....	23	Stoughton, A. V.,	Claremont.....	10
Smith, E. W.,	San Francisco.....	11	Sprague, B. H.,	Los Angeles.....	10	Stovall, L.,	Los Angeles.....	10
Smith, F. H.,	Salinas.....	14	Sprague, G. T.,	Van Nuys.....	10	Stowe, O. P.,	Oakland.....	1
Smith, F. H.,	San Bruno.....	26	Sprauer, V. J.,	Los Angeles.....	10	Stowe, W. P.,	San Francisco.....	23
Smith, G. F.,	Los Angeles.....	10	Spruance, H. E.,	San Diego.....	22	Strahlmann, L.,	San Diego.....	22
Smith, H.,	Los Angeles.....	10	Staatz, A. D.,	Olive View.....	10	Strange, S. P.,	San Francisco.....	23
Smith, H. A.,	Whittier.....	10	Stabel, F.,	Redding.....	30	Stratford, E. B.,	Los Angeles.....	10
Smith, H. C.,	Glendale.....	10	Stadfield, C. G.,	Hollywood.....	10	Strathearn, H. J.,	Hollywood.....	10
Smith, H. G.,	Palo Alto.....	28	Stadlinger, K. P.,	Burbank.....	10	Stratton, E. K.,	San Francisco.....	23
Smith, H. H.,	Los Angeles.....	10	Stadtherr, E. F.,	San Francisco.....	23	Stratton, G. W.,	Marysville.....	39
Smith, H. J.,	Oakland.....	1	Stadtmueller, E. S.,	San Francisco.....	23	Stratton, J. M.,	Berkeley.....	1
Smith, H. L.,	Fair Oaks.....	19	Stafford, C. C.,	Marysville.....	25	Streaker, L. H.,	Goleta.....	27
Smith, H. MacV.,	Santa Ana.....	16	Stafford, C. E.,	Los Angeles.....	10	Street, L. A. B.,	Los Angeles.....	10
Smith, J.,	Bakersfield.....	7	Stafford, D. D.,	Alameda.....	1	Strickler, D.,	San Francisco.....	23
Smith, J. H.,	Colton.....	18	Stafford, H. E.,	Oakland.....	1	Strickler, J. P.,	San Francisco.....	23
Smith, J. L.,	Los Angeles.....	10	Stafford, O. R.,	Los Angeles.....	10	Striegel, L. McC.,	Long Beach.....	10
Smith, J. R.,	Fresno.....	4	Stahl, W. F.,	Los Angeles.....	10	Striegel, R. J.,	Long Beach.....	10
Smith, K. B.,	Oakland.....	1	Stalley, H. D.,	Los Angeles.....	10	Strietmann, W. H.,	Oakland.....	1
Smith, L. D.,	Stockton.....	20	Stanford, K. J.,	Fresno.....	4	Strong, A. J.,	Santa Paula.....	37
Smith, L. E.,	Hollister.....	24	Stanley, L. L.,	San Rafael.....	11	Strongin, S.,	Bakersfield.....	7
Smith, L. E.,	San Bernardino.....	21	Stanton, E. H.,	Glendora.....	10	Struble, H. P.,	Hayward.....	22
Smith, L. W.,	Los Angeles.....	10	Stanton, F. E.,	Long Beach.....	10	St. Sure, F. A.,	San Diego.....	1
Smith, M.,	Los Angeles.....	10	Stanton, R. H.,	Pasadena.....	10	Stump, F. M.,	Crescent City.....	5
Smith, M. H.,	Hollywood.....	10	Starbird, G. A.,	King City.....	14	Sturdivant, B. F.,	Pasadena.....	10
Smith, N. R.,	Monterey Park.....	10	Stark, B. W.,	San Francisco.....	23	Sturgeon, C. T.,	Los Angeles.....	10
Smith, P. M.,	San Francisco.....	23	Stark, J. H.,	Oakland.....	1	Sturges, R. L.,	Los Angeles.....	10
Smith, R. D.,	Pomona.....	10	Stark, M.,	Los Angeles.....	10	Styan, W. E.,	San Francisco.....	26
Smith, R. D.,	San Pedro.....	10	Starr, R. W.,	Los Angeles.....	10	Sudlow, E. L.,	San Fernando.....	10
Smith, R. E.,	Los Angeles.....	10	Staub, J. S.,	San Jose.....	28	Suehs, P. E.,	San Francisco.....	23
Smith, R. K.,	San Francisco.....	23	Stauffer, M. L.,	Pittsburg.....	3	Sugar, H.,	Los Angeles.....	10
Smith, R. L.,	Pomona.....	10	Stealy, C. L.,	San Diego.....	22	Suglian, V. V.,	San Francisco.....	23
Smith, R. L. I.,	Pasadena.....	10	Steddem, F. W.,	Los Angeles.....	10	Sullivan, C. S.,	San Jose.....	28
Smith, R. M.,	Riverside.....	18	Steele, A. A.,	Los Angeles.....	10	Sullivan, D. F.,	Oakland.....	1
Smith, R. N.,	Los Angeles.....	10	Steele, A. B.,	Santa Barbara.....	27	Sullivan, J. J.,	Oakland.....	1
Smith, R. T.,	Pomona.....	10	Steele, E. H.,	Los Angeles.....	10	Sullivan, J. M.,	San Francisco.....	23
Smith, S.,	Pasadena.....	10	Steele, J. T.,	Dunsmuir.....	31	Sullivan, J. R.,	San Francisco.....	23
Smith, S. K.,	Oakland.....	1	Steele, M. T.,	Los Angeles.....	10	Sullivan, N. R.,	Santa Cruz.....	29
Smith, T. B.,	Wilmington.....	10	Steen, C. E.,	Brea.....	16	Sullivan, W.,	Ahuwahnee.....	23
Smith, W.,	Los Angeles.....	10	Steen, E. J.,	Fullerton.....	16	Sullivan, W. J.,	Hollywood.....	10
Smith, W. B.,	Los Angeles.....	10	Steele, R. A.,	Downey.....	10	Sulzbacher, C. I.,	Los Angeles.....	10
Smith, W. B.,	San Francisco.....	23	Steffy, J. L.,	Santa Monica.....	10	Summerlin, H. S.,	San Diego.....	22
Smith, W. B.,	Delano.....	10	Stegeman, W.,	Crescent City.....	5	Sundberg, R. H.,	San Diego.....	22
Smith, W. S.,	San Diego.....	22	Stein, C.,	Bellflower.....	10	Sundin, P. O.,	Los Angeles.....	10
Smithies, H. R.,	Alameda.....	1	Stein, J. L.,	Albany.....	1	Sunzeri, A. T.,	San Jose.....	28
Smolt, C. A.,	Ventura.....	37	Stein, W. F.,	Fresno.....	4	Suski, P. M.,	Los Angeles.....	10
Smolt, L. P.,	Ventura.....	37	Steinberg, J.,	Los Angeles.....	10	Susnow, D. A.,	San Francisco.....	23
Smyle, R. S.,	San Diego.....	22	Steinert, G.,	Galt.....	27	Sutherland, K. H.,	Santa Ana.....	16
Smyth, F. S.,	San Francisco.....	23	Steinmetz, A. F.,	Hayward.....	1	Sutherland, P. R.,	Los Angeles.....	10
Smyth, M. H.,	Stockton.....	24	Steiss, C. F.,	San Francisco.....	23	Sutherland, R. T.,	Oakland.....	1
Smyth, R. J.,	Cayucos.....	25	Stelhorn, A. F.,	Rosemead.....	10	Sutherland, C. G.,	Los Angeles.....	10
Smythe, H.,	Stockton.....	24	Stellar, R. W.,	Wilmington.....	1	Sutton, T. L.,	Stockton.....	24
Snedden, C. M.,	Long Beach.....	10	Stephens, B. M.,	Alameda.....	1	Svoboda, F. C.,	San Diego.....	22
Snoddy, C. A.,	Vallejo.....	32	Stephens, B. P.,	Oakland.....	1	Swanson, C. F.,	Los Angeles.....	10
Snook, H. J.,	Oakland.....	1	Stephens, H. W.,	San Francisco.....	23	Swarts, R. E.,	Hartford, Conn.....	26
Snow, H. L.,	San Pedro.....	10	Stephens, J. S.,	Los Angeles.....	10	Swager, L. S.,	Oakland.....	1
Snow, W. F.,	New York, N. Y.....	28	Stephens, P. H.,	Los Angeles.....	10	Swearingen, F. C.,	Pomona.....	10
Snure, H.,	Los Angeles.....	10	Stephens, W. B.,	Alameda.....	1	Sweeney, A. H.,	Fresno.....	4
Snyder, A. D.,	Los Angeles.....	10	Stephens, W. C.,	Pasadena.....	10	Sweeney, J. P.,	Milbrae.....	26
Snyder, C. C.,	Pasadena.....	10	Stephenson, H. A.,	San Francisco.....	23	Sweet, C. D.,	Oakland.....	1
Snyder, G. A.,	West Los Angeles.....	10	Stern, R. G.,	Los Angeles.....	10	Sweet, E.,	Los Angeles.....	10
Snyder, G. S.,	San Francisco.....	23	Stern, R. L.,	Los Angeles.....	10	Sweet, F. D.,	Long Beach.....	10
Snyder, W. H.,	Hollywood.....	10	Steven, R. A.,	San Francisco.....	23	Sweetser, G. W.,	Martinez.....	3
Sobey, G. L.,	Paso Robles.....	25	Stevens, C. S.,	Santa Barbara.....	27	Swengel, W. F.,	Monterey.....	14
Sogemeler, E.,	San Mateo.....	26	Stevens, G. M.,	Los Angeles.....	10	Swenson, R. T.,	Sherman Oaks.....	10
Soghor, S.,	Los Angeles.....	10	Stevens, J. B.,	Los Angeles.....	10	Swett, W. F.,	San Francisco.....	23
Sohler, F. E.,	Healdsburg.....	33	Stevens, W. E.,	San Francisco.....	23	Sweczy, S.,	Los Angeles.....	10
Sohler, F. E., Jr.,	Cloverdale.....	33	Stevens, W. L.,	Baldwin Park.....	10	Swift, L. M.,	Marysville.....	39
Solland, A.,	Los Angeles.....	10	Stevenson, A. P.,	Torrance.....	10	Swigart, M.,	Monterey.....	14
Sokol, L. I.,	Los Angeles.....	10	Stevenson, C. C.,	Oakland.....	1	Swim, W. A.,	Los Angeles.....	10
Solomon, J. C.,	Los Angeles.....	10	Stevenson, G. L.,	Sacramento.....	19	Swindt, J. K.,	Pomona.....	10
Solomon, W. O.,	Oakland.....	1	Stevenson, G. R.,	San Diego.....	22	Swindt, J. M.,	Chino.....	21
Somerfeld, E.,	Los Angeles.....	10	Stevenson, S. L.,	San Francisco.....	23	Swinney, R. W.,	Long Beach.....	10
Somerfeld, H. A.,	San Francisco.....	23	Stewart, A. E.,	Los Angeles.....	10	Syer, W. H.,	Los Angeles.....	10
Somers, M. R.,	San Francisco.....	23	Stewart, H. B.,	Ripon.....	34	Syman, L. W.,	Los Angeles.....	10
Sommer, E. A.,	Chino.....	21	Stewart, H. J.,	San Diego.....	22	Symonds, C. W.,	Pasadena.....	10
Sonnenberg, S. G.,	Los Angeles.....	10	Stewart, S. F.,	Los Angeles.....	10	Szukalski, J. P.,	Pasadena.....	10
Sonnenberg, A.,	San Francisco.....	23	Stewart, W.,	Los Angeles.....	10			
Sooy, D. W.,	San Francisco.....	23	St. Geme, J. W.,	Los Angeles.....	10			
Soper, H. V.,	Los Angeles.....	10	Stibbens, F. H.,	Oakland.....	1			
Soracco, C. V.,	Placerville.....	19	Stickler, J. H.,	Pasadena.....	10			
Sorau, B. M.,	Fresno.....	4	Stiles, F. E.,	San Francisco.....	23			
Sorsnen, A. A.,	Los Angeles.....	10	Stilson, G. D.,	Long Beach.....	10			
Sosnowski, K. C.,	Long Beach.....	10	Stilwell, L. E.,	Hollywood.....	10			
Soto-Hall, R.,	San Francisco.....	23	Stimson, C. A.,	Petaluma.....	3			
Soutar, R. G.,	Sacramento.....	19	Stirewalt, H. W.,	Concord.....	33			
Southgate, Paul T.,	Long Beach.....	10	St. John, A. H. V.,	Los Angeles.....	23			
Spalding, A. B.,	San Francisco.....	23	Stoddard, C. L.,	San Diego.....	10			
Spalding, C. A. H.,	Richmond.....	3	Stoddard, J. McC.,	Beverly Hills.....	20			
Spalding, J. B.,	Richmond.....	3	Stoddard, T. A.,	San Francisco.....	23			
Spalding, R. B.,	San Francisco.....	23	Stoker, E. M.,	San Francisco.....	23			
Spaulding, A. Q.,	Santa Barbara.....	27	Stoll, A. H.,	Oxnard.....	37			
Spaulding, J. M.,	Los Angeles.....	10	Stolle, F.,	Dixon.....	32			
Spear, E. B.,	Los Angeles.....	10	Stolz, C. E.,	Los Angeles.....	1			
Spear, J. L.,	Santa Rosa.....	33	Stolz, H. R.,	Berkeley.....	1			
Speer, G. G.,	Los Angeles.....	10	Stone, B.,	San Francisco.....	23			
Spelk, F. A.,	Los Angeles.....	10	Stone, C. S.,	Santa Barbara.....	27			
Spencer, G. A.,	Sacramento.....	19	Stone, R. S.,	San Francisco.....	23			
Spencer, R. M.,	Los Angeles.....	10	Stone, W. J.,	Pasadena.....	10			
Sperling, S.,	Los Angeles.....	10	Stookey, I. J.,	San Francisco.....	23			
Sperling, S. J.,	Los Angeles.....	10	Stoops, R. P.,	Oakland.....	1			
Spiegel, M. J.,	Los Angeles.....	10	Storey, T. A.,	Stanford University.....	28			
Spiers, H. W.,	Los Angeles.....	10	Stork, V. E.,	Los Angeles.....	10			

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Wallace, J. A.,	Calipatria.....	6	Weseman, R. J.,	Novato	11	Wilson, H. S.,	N. Hollywood.....	10
Wallace, W. S.,	Orange	16	Wessels, A. L.,	Salinas.....	14	Wilson, J. B.,	San Francisco.....	23
Wallach, I. A.,	Los Angeles.....	10	Wessels, W. F.,	Los Angeles.....	10	Wilson, J. C.,	San Jose.....	23
Wallentine, N. R.,	Long Beach.....	10	Wessly, W. D.,	Glendale.....	10	Wilson, J. C.,	Los Angeles.....	10
Waller, G. P., Jr.,	Trail, Oregon.....	10	Wesson, M. B.,	San Francisco.....	23	Wilson, J. D.,	Berkeley.....	1
Waller, L. M.,	Hollywood.....	10	West, F. D.,	Beaumont.....	18	Wilson, J. M.,	Pasadena.....	10
Wallerius, R. M.,	Sacramento.....	19	West, H. F.,	Los Angeles.....	10	Wilson, J. W.,	San Francisco.....	23
Walrath, G. B.,	Los Angeles.....	10	Weston, F. P.,	Pasadena.....	10	Wilson, J. W., Jr.,	Los Angeles.....	10
Walsh, F. D.,	Oakland.....	1	Weston, F. W.,	Tustin.....	16	Wilson, L. E.,	Orange.....	16
Walsh, J. F.,	Eureka.....	5	Westphal, G. A.,	Elsinore.....	18	Wilson, K. R.,	Santa Barbara.....	27
Walter, F. J.,	San Diego.....	22	Westphal, H. G.,	Glendale.....	10	Wilson, R. D.,	Los Angeles.....	10
Walters, C. M. C.,	Los Angeles.....	10	Wetherill, G. G.,	San Diego.....	22	Wilson, W. M.,	Weaverville.....	30
Walters, H. S.,	San Luis Obispo.....	25	Wetmore, C. T.,	Berkeley.....	1	Wimmer, S. D.,	Los Angeles.....	10
Walters, P. R.,	Berkeley.....	1	Wever, G. K.,	Stockton.....	24	Wimp, W. H.,	Laguna Beach.....	10
Walton, G. E.,	Oakland.....	1	Whalen, J. F.,	Attadena.....	10	Wind, E.,	Hollywood.....	10
Walton, H. M.,	Loma Linda.....	21	Whalen, T. J.,	San Francisco.....	23	Wineberg, A. C.,	Oakland.....	1
Walton, R. R.,	Linwood.....	10	Whalman, H. F.,	Los Angeles.....	10	Wineland, A. J.,	Los Angeles.....	10
Warburton, J. A.,	Burlingame.....	26	Wheatley, W. G.,	Azusa.....	10	Wing, L. A.,	Eureka.....	5
Ward, R.,	San Francisco.....	23	* Wheeler, I. A.,	Colfax.....	33	Winn, W. A.,	Springville.....	36
Wardrip, B. H.,	San Jose.....	28	Wheeler, O. W.,	Riverside.....	18	Winnard, W. F. R.,	Los Angeles.....	10
Ware, E. R.,	Los Angeles.....	10	Whcelis, J. M.,	Beverly Hills.....	10	Winslow, A. L.,	Oakland.....	1
Ware, J. C.,	Santa Barbara.....	27	Whitaker, L. S.,	San Jose.....	28	Winterberg, W. H.,	San Francisco.....	23
Warmer, C. A.,	Los Angeles.....	10	Whitcomb, E. L.,	Los Angeles.....	10	Winternitz, C. D.,	San Francisco.....	23
Warner, H. E.,	Los Angeles.....	10	Whitc, A. S.,	San Francisco.....	23	Winters, W. P.,	San Diego.....	22
Warner, O. H.,	San Diego.....	22	White, H. L.,	Redding.....	30	Wiper, T. B.,	San Francisco.....	23
Warnock, A. W.,	San Pedro.....	10	White, J. F.,	San Diego.....	22	Wise, D. C.,	Pittsburg.....	3
Warnshuis, F. C.,	San Francisco.....	23	White, J. H.,	Chico.....	2	Wise, P. L.,	San Jose.....	28
Warren, H. C.,	Belmont.....	26	White, L. F.,	Los Angeles.....	10	Wisner, F. B.,	Marysville.....	39
Warren, J. P.,	San Francisco.....	23	White, M. D.,	Ontario.....	21	Wissner, L. O.,	Modesto.....	34
Warren, J. W.,	Los Angeles.....	10	White, P. G.,	Los Angeles.....	10	Witherbee, H. R.,	Los Angeles.....	10
Warren, J. W.,	National City.....	22	Whitelock, T. S.,	San Diego.....	22	* Witherbee, O. O.,	Los Angeles.....	10
Washburn, W. W.,	San Francisco.....	23	Whitelock, T. S., Jr.,	San Diego.....	22	Witter, C. B.,	Los Angeles.....	10
Watanabe, L. M.,	San Jose.....	28	Whiting, F. M.,	Orville.....	2	Wold, A. P.,	Oakland.....	1
Waters, P. S.,	Patton.....	21	Whitlow, J. E.,	Fillmore.....	10	Wolf, G. L.,	San Francisco.....	23
Waters, Z. O.,	San Francisco.....	23	Whitmer, C. F.,	Colton.....	21	Wolfe, H. H.,	Fort Bragg.....	12
Watke, L. E.,	Tulare.....	36	Whitney, H. H.,	Burlingame.....	26	Wolfe, E.,	San Francisco.....	23
Watkins, L. H.,	Pasadena.....	10	Whitsett, J. W.,	Los Angeles.....	10	Wolff, F. S.,	San Francisco.....	23
Watkins, W. E.,	Santa Ana.....	16	Whittaker, L. F.,	Huntington Beach.....	16	Wolff, M. J.,	Los Angeles.....	10
Watson, A. R.,	Eureka.....	5	Wickman, H. J.,	Riverside.....	18	Wolfson, L. H.,	Modesto.....	34
Watson, F. R.,	San Mateo.....	26	Wiede, D.,	Reedley.....	4	Wolfsohn, J. M.,	San Francisco.....	23
Watson, F. V.,	Hollywood.....	10	Wiebe, F. E.,	Salinas.....	14	Wolfsohn, M.,	Monterey.....	14
Watson, H. G.,	San Francisco.....	23	Wiebusch, E. G. L.,	Los Angeles.....	10	Wolfson, I. E.,	Los Angeles.....	10
Watson, L. F.,	Los Angeles.....	10	Wiel, H. I.,	San Francisco.....	23	Wong, T. A.,	Los Angeles.....	23
Watson, R. G.,	Oakland.....	1	Wiens, F. L.,	Porterville.....	36	Wood, C. H.,	Glendora.....	10
Watson, T.,	Sunnyvale.....	28	Wier, T. F.,	San Diego.....	22	Wood, C. L.,	St. Helena.....	15
Watters, E. M.,	Santa Cruz.....	29	Wiese, W. F.,	Fresno.....	4	Wood, D. A.,	San Francisco.....	23
Watters, H. G.,	Watsonville.....	29	Wightman, A. H.,	Laguna Beach.....	16	Wood, D. A.,	San Francisco.....	23
Waxman, A.,	Los Angeles.....	10	Wilbur, B. C.,	Palo Alto.....	28	Wood, F. W.,	Alhambra.....	10
Way, S. C.,	San Francisco.....	23	Wilbur, R. L.,	Stanford University.....	23	Wood, G. J.,	St. Helena.....	15
Wayburn, E.,	San Francisco.....	23	Wilcox, A. B.,	Santa Barbara.....	27	Wood, G. N., Jr.,	Palo Alto.....	28
Wayland, C.,	San Jose.....	28	Wilcox, C. F.,	Huntington Park.....	10	Wood, H. A.,	Beaumont.....	18
Wayland, R. T.,	Glendale.....	10	Wilcox, M. R.,	Los Angeles.....	10	Wood, J. A.,	Anaheim.....	16
Wayte, E. W.,	Norwalk.....	10	Wilcox, R. W.,	Long Beach.....	10	Wood, J. G.,	Los Angeles.....	10
Weaver, C. H.,	Los Angeles.....	10	Wildcr, E. M.,	Sacramento.....	19	Wood, O. T.,	Red Bluff.....	35
Weaver, D. D.,	Oakland.....	1	Wiley, E. H.,	Los Angeles.....	10	Wood, R. F.,	National City.....	22
Weaver, L. W.,	Redlands.....	1	Wiley, H. J.,	Huntington Park.....	10	Wood, W. A.,	Oakland.....	1
Webber, W. T.,	Long Beach.....	10	Wilhelm, L. F. X.,	Los Angeles.....	10	Woodard, D. S.,	Watsonville.....	29
Weber, A. L.,	Upland.....	21	Wilhoit, J. W.,	Ocean Beach.....	22	Woodhull, C. G.,	Los Angeles.....	10
Weber, W. L.,	Los Angeles.....	10	Wilke, J. O.,	Hermosa Beach.....	10	Woodhull, R. A.,	Los Angeles.....	10
Webster, D. P.,	Fresno.....	4	Wilken, H. T.,	Santa Monica.....	10	* Woods, D. K.,	San Diego.....	22
Webster, G. M.,	Patton.....	21	Wilkinson, A. J.,	San Diego.....	22	Woods, D. L.,	Los Angeles.....	10
Webster, J. C.,	Los Angeles.....	10	Wilkinson, A. M.,	Hollywood.....	10	Woods, L.,	Oakland.....	1
Webster, J. S.,	Mariposa.....	13	Willard, W. P.,	San Francisco.....	23	Woods, N. C.,	Alhambra.....	10
Webster, O. L.,	Holtville.....	6	Willcutt, G. H.,	San Rafael.....	11	Woods, R. A.,	Los Angeles.....	10
Weddle, C.,	Dinuba.....	36	Willems, L. C.,	Glendale.....	10	Woods, W. W.,	Alhambra.....	10
Wedgewood, P. E.,	San Diego.....	23	Williams, A. H.,	Belmont.....	27	Woodward, E. B.,	Monrovia.....	10
Weeks, A.,	San Francisco.....	23	Williams, A. J.,	San Francisco.....	23	Woolf, M. S.,	San Francisco.....	23
Weeks, C. L.,	Los Angeles.....	10	Williams, A. W.,	Los Angeles.....	10	Woolfan, E. B.,	Los Angeles.....	10
Wehrly, J.,	Santa Ana.....	16	Williams, C. G.,	Santa Monica.....	10	Woolford, J. S.,	Eureka.....	5
Wehrly, W. S.,	Santa Ana.....	16	Williams, D. B.,	Colton.....	21	Woolsey, C. H.,	San Francisco.....	23
Weil, S. N.,	Rodeo.....	3	Williams, D. R.,	Veterans Home.....	15	Woolsey, J. H.,	Woodland.....	38
Weinberg, S. L.,	Los Angeles.....	10	Williams, E. H.,	Los Angeles.....	10	Woolston, W. J.,	Pasadena.....	10
Weinberger, J.,	San Diego.....	22	Williams, F.,	San Francisco.....	23	Workman, R. A.,	Pacific Grove.....	14
Weiner, W. M.,	San Francisco.....	23	Williams, F. E., Jr.,	Patton.....	21	Worster, W. W.,	San Gabriel.....	10
Weiser, A. D.,	Los Angeles.....	10	Williams, J.,	Eldridge.....	33	Worthington, L. C.,	Bakersfield.....	7
Weiskotten, W. O.,	San Diego.....	22	Williams, J. B.,	Los Angeles.....	10	Worthington, R. L.,	San Diego.....	22
Weiss, K. F.,	Visalia.....	36	Williams, J. C.,	San Francisco.....	23	Wright, E. W.,	Los Angeles.....	10
Weitkamp, A. H.,	Los Angeles.....	10	Williams, N. H.,	Los Angeles.....	10	Wright, C. A.,	Los Angeles.....	10
Welbourn, L. S.,	Van Nuys.....	10	Williams, P. M.,	Los Angeles.....	10	Wright, H. J.,	Healdsburg.....	33
Welbourn, M. A.,	Los Angeles.....	10	Williams, R.,	Los Angeles.....	10	Wright, J. M.,	Pasadena.....	10
Welbourn, P. M.,	Los Angeles.....	10	Williams, W. F.,	Oakland.....	1	Wright, K. D.,	Venice.....	10
Welch, E. H.,	Pomona.....	10	Williamson, M. A.,	Lone Pine.....	7	Wright, L. V.,	San Francisco.....	23
Welch, S. H.,	Glendale.....	10	Williamson, M. C.,	Upland.....	21	Wright, R. W.,	Palo Alto.....	28
Welcome, E. H.,	Downey.....	10	Williamson, N. E.,	Stockton.....	24	Wright, W. B., Jr.,	Long Beach.....	10
Welfer, C. R.,	Los Angeles.....	10	Williamson, R. G.,	Ontario.....	21	Wright, W. M.,	Los Angeles.....	10
Weller, T. W.,	Oakland.....	1	Willier, A. F.,	San Diego.....	22	Wrigley, G. C.,	Sonora.....	24
Wellman, O. F.,	San Pedro.....	10	Willis, H. Q.,	Balboa.....	16	Wyckoff, H. A.,	San Francisco.....	23
Wells, C. E.,	Woodlake.....	36	Willits, E. K.,	San Francisco.....	23	Wyers, R. E.,	Spadra.....	10
Wells, E. W.,	Los Angeles.....	10	Wills, C. A.,	Oakland.....	1	Wylie, C. A.,	San Bernardino.....	21
Wells, G. D.,	Los Angeles.....	10	Wills, I.,	Santa Barbara.....	27	Wymore, W. W.,	San Francisco.....	23
Wells, J. T.,	San Diego.....	22	Willson, L. R.,	Fresno.....	4	Wynns, H. LeR.,	Berkeley.....	1
Wells, M. C.,	Los Angeles.....	10	Wilmar, A. H.,	Paso Robles.....	25			
Wells, P. H.,	Arcadia.....	15	Wilson, C.,	Los Angeles.....	10			
Wells, S.,	San Francisco.....	19	Wilson, C. A.,	Los Angeles.....	10			
Welpton, M. A.,	San Diego.....	22	Wilson, C. G.,	Palo Alto.....	28			
Welsh, O. A.,	Ventura.....	37	Wilson, D. R.,	San Jose.....	28			
Weltl, L.,	Napa.....	15	Wilson, G.,	Sacramento.....	19			
Wemple, E. L.,	Verdugo City.....	10	Wilson, G. W.,	Los Angeles.....	10			
Werden, D. H.,	San Diego.....	22	Wilson, H. F.,	San Francisco.....	23			
Werlich, R. E.,	San Diego.....	22	Wilson, H. H.,	Los Angeles.....	10			
Werner, E. A.,	Los Angeles.....	10	Wilson, H. P.,	Whittier.....	10			
Werthmann, P. A.,	Gustine.....	13	Wilson, H. R.,	Modesto.....	34			

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Yabroff, S. W.,	Oakland.....	1
Yaker, D. N.,	Los Angeles.....	10
Yamao, E.,	Walnut Grove.....	19
Yates, J. E.,	Sacramento.....	19
Yeagle, R. P.,	Santa Ana.....	16
Yerxa, C. W.,	Los Angeles.....	10
Yoakam, F. A.,	Moorpark.....	37

NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.	NAME	CITY	COUNTY SOCIETY NO.
Yocum, F. W., <i>Oakdale</i>		25	Kahn, A. J., <i>Los Angeles</i>		23	Simmons, G. C., <i>Inverness</i>		19
Yoder, E. H., <i>Los Angeles</i>		10	Lindsay, W. K., <i>Sacramento</i>		19	Smith, J. F., <i>San Francisco</i>		23
Yoell, R. A., <i>San Francisco</i>		23	Livingston, W. R., <i>Oxnard</i>		37	Somers, H., <i>Morgan Hill</i>		23
Yost, F. O., <i>Los Angeles</i>		10	Lorini, R., <i>Paris, France</i>		22	Spencer, J. C., <i>Palo Alto</i>		23
Young, B. A., <i>Long Beach</i>		10	MacDonald, E. A., <i>Beverly Hills</i>		21	Spiro, H., <i>San Francisco</i>		23
Young, C. S., <i>Los Angeles</i>		10	MacLaughlin, W. E., <i>Los Angeles</i>		10	Spriggs, G. A., <i>San Francisco</i>		23
Young, D. D., <i>Los Angeles</i>		10	* March, W. B., <i>Burson</i>		24	Taylor, M. C., <i>Stockton</i>		24
Young, E. N., <i>San Diego</i>		22	McClenahan, H. C., <i>San Francisco</i>		23	Vecki, V. G., <i>San Francisco</i>		23
Young, F. B., <i>Long Beach</i>		10	McDaniel, J. L., <i>San Fernando</i>		10	Wagner, H. L., <i>San Francisco</i>		23
Young, H. M., <i>San Diego</i>		22	McKee, A. B., <i>Redwood City</i>		23	Wall, A. S., <i>Los Angeles</i>		10
Young, J. H., <i>San Diego</i>		22	McVey, C. L., <i>Oakland</i>		1	Waller, J. L., <i>San Francisco</i>		23
Young, J. P., <i>Lemoore</i>		8	Melvin, J. T., <i>Porterville</i>		36	Ward, M. W., <i>San Francisco</i>		38
Young, J. W., <i>Beverly Hills</i>		10	* Newman, H. P., <i>San Diego</i>		22	Waterman, H. J., <i>Berkeley</i>		23
Young, M. L., <i>North Hollywood</i>		10	Pope, E. W., <i>San Francisco</i>		23	Weirich, E. W., <i>Angels Camp</i>		24
Young, N. A., <i>Huntington Park</i>		10	Power, H., <i>Palo Alto</i>		28	Wheeler, J. S., <i>Santa Cruz</i>		17
Young, R. A., <i>Oakland</i>		1	Quinn, W., <i>San Francisco</i>		23	Whiffen, R. A., <i>San Jose</i>		28

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Zaiser, H. E., <i>Orange</i>	16
Zanger, H. G., <i>San Jose</i>	28
Zantiny, W. G., <i>Long Beach</i>	10
Zeff, M. G., <i>Berkeley</i>	1
Zeiler, A. H., <i>Los Angeles</i>	10
Zeiler, J., <i>Los Angeles</i>	10
Zeimer, I. S., <i>Stockton</i>	24
Zelinsky, F., <i>Los Angeles</i>	10
Zeller, W. C., <i>Visalia</i>	36
Zieber, R. L., <i>Santa Rosa</i>	33
Zimmerer, S. R., <i>Mecca</i>	18
Zimmerman, H., <i>Sacramento</i>	19
Zimmermann, W. T., <i>Los Angeles</i>	10
Zirker, D. W., <i>Merced</i>	13
Zirkle, T. I., <i>Loma Linda</i>	21
Ziskind, E., <i>Los Angeles</i>	10
Zobel, A. J., <i>San Francisco</i>	23
Zobel, J. F., <i>San Francisco</i>	23
Zochert, L. W., <i>La Mesa</i>	22
Zombro, F. B., <i>Los Angeles</i>	10
Zook, A. J., <i>Burbank</i>	10
Zorb, G. A., <i>Los Angeles</i>	10
Zumwalt, E. R., <i>Tulare</i>	36
Zumwalt, F. H., <i>San Francisco</i>	23
Zumwalt, R. H., <i>San Francisco</i>	23

* * *

II. ASSOCIATE MEMBERS

Cummins, W. T., <i>San Francisco</i>	23
Godfrey, E. B., <i>San Bernardino</i>	21
Leake, C. D., <i>San Francisco</i>	23
Mosher, C. D., <i>Stanford University</i>	28
Rusk, G. Y., <i>San Francisco</i>	23
Weiss, C., <i>San Francisco</i>	23

* * *

III. HONORARY MEMBERS

* Goodenow, H. N., <i>Monrovia</i>	10
Harris, H., <i>San Francisco</i>	23
Hermann, A. J., <i>Los Angeles</i>	10
Kalb, G. B., <i>Monrovia</i>	10
Kellogg, F. B., <i>Santa Monica</i>	10
King, J. C., <i>Riverside</i>	18
* Liliencrantz, A., <i>Oakland</i>	1
Perry, W. F., <i>Los Angeles</i>	10
Sanders, A. O., <i>San Francisco</i>	10
Shawhan, R. C., <i>Ottum, N. C.</i>	10
Sill, E. R., <i>Oakland</i>	1

* * *

IV. RETIRED MEMBERS

Allen, F. M., <i>San Diego</i>	22
Baker, C. Le B. J., <i>Point Loma</i>	22
Baker, F., <i>Point Loma</i>	22
* Baumeister, E. E., <i>San Francisco</i>	2
Bogue, H. A., <i>Ontario</i>	21
Browning, C. C., <i>Los Angeles</i>	10
Bryan, E. H., <i>Penryn</i>	17
Clark, J., <i>Gilroy</i>	28
Davis, B., <i>Los Gatos</i>	13
DePuy, E. S., <i>Oakland</i>	1
* Doig, R. L., <i>Berkeley</i>	22
Dunsnoor, N. C., <i>Los Angeles</i>	10
Evans, G. H., <i>Berkeley</i>	23
Frederick, M. W., <i>Brentwood</i>	23
Catchell, W. LeF., <i>Chico</i>	2
Goodman, E., <i>San Francisco</i>	23
Goodridge, H. A., <i>San Jose</i>	28
Gray, F. P., <i>San Francisco</i>	23
Grissim, J. D., <i>Oakland</i>	1
Gunn, Herbert, <i>San Francisco</i>	10
Henderson, J. J., <i>San Francisco</i>	23
Hogan, J. J., <i>Vallejo</i>	23
Jean, G. W., <i>Santa Barbara</i>	27

IN MEMORIAM—1936

Allen, John, October 4, 1936, Raymond.
Ames, Elwin Witt, April 6, 1936, Los Angeles.
Arnold, Mott Hunton, December 9, 1936, San Diego.
Ball, Jau Don, November 25, 1936, San Francisco.
Baumeister, Edward Emery, May 3, 1936, San Francisco.
Beard, John Lyman, November 9, 1936, Martinez.
Beattie, Hugh, September 18, 1936, Elk Grove.
Beckett, Wesley Wilbur, June 3, 1936, Los Angeles.
Bigby, Margaret H., September 26, 1936, Downey.
Bixby, Edward Marcellus, April 24, 1936, San Francisco.
Bonta, Maurice Buford, January 5, 1936, Los Angeles.
Brendel, Frank Philip, May 24, 1936, Sacramento.
Brewer, Lambert Cleveland, May 11, 1936, Los Angeles.
Burg, Beatrice Victoria, April 4, 1936, Oakland.
Buskirk, William H., August 7, 1936, Los Angeles.
Chase, Raymond E., July 14, 1936, Glendale.
Chidester, Walter Clifford, April 21, 1936, San Mateo.
Collings, Harry Andrews, March 8, 1936, Susanville.
Doig, Robert L., May 9, 1936, San Diego.
Dougherty, Edwin E., July 17, 1936, Los Angeles.
Duffield, William, September 9, 1936, Los Angeles.
Fisher, Charles Albert, June 20, 1936, Los Angeles.
Gatliff, William Walker, May 12, 1936, Butte City.
Golding, Daniel G., April 28, 1936, Santa Monica.
Graham, John Alexander, January 1, 1936, Barstow.
Goodenow, Norman H., October 14, 1936, Monrovia.
Hare, George Andrew, April 4, 1936, Fresno.
Harrison, Fred, April 24, 1936, Gridley.
Hawley, Max Charles, January 1, 1936, Agnew.
Heald, Alfred Henry, March 12, 1936, San Mateo.
Hemken, Louisa, November 20, 1936, Los Angeles.
Hicks, John R., August 1, 1936, Tulare.
Hieronymus, Arthur, December 5, 1936, Alameda.

Hubble, J. Edgar, July 30, 1936, Pomona.
Kendall, Oscar J., November 18, 1936, San Diego.
Kirkpatrick, John L., May 17, 1936, Los Angeles.
Lackey, Howard Julian, May 15, 1936, Oakland.
Lagan, Edward, May 17, 1936, San Francisco.
Langnecker, Harry Leslie, September 23, 1936, San Francisco.
Latta, Samuel E., June 13, 1936, Stockton.
Lilientcrantz, August, October 9, 1936, Oakland.
Lund, Charles W., November 4, 1936, Willows.
Macleish, Archibald Campbell, May 4, 1936, Los Angeles.
March, William Bright, June 23, 1936, Burson.
Matsumura, Kiyoshi, January 5, 1936, San Francisco.
Merrill, Edward Roscoe, February 13, 1936, Santa Barbara.
Miner, Lucien L., June 5, 1936, Los Angeles.
Moore, Thomas Verner, June 6, 1936, San Jose.
Newman, Henry Parker, September 23, 1936, San Diego.
Noggle, George Elliott, April 8, 1936, Chino.
Oatman, Homer Clifton, January 1, 1936, San Diego.
O'Donnell, Earl William, February 16, 1936, Los Angeles.
Offield, Archie Leonard, September 17, 1936, Burlingame.
Rathbun, William T., January 2, 1936, Colusa.
Richter, Clemens Max, May 19, 1936, San Francisco.
Rigdon, Rufus Lee, January 21, 1936, San Francisco.
Roath, Clinton, January 26, 1936, Los Angeles.
Rosoff, James A., January 24, 1936, Compton.
Rothschild, Max, July 11, 1936, San Francisco.
Striegel, Raymond John, February 26, 1936, Long Beach.
Thieme, Derk Anthony I., October 5, 1936, Los Angeles.
Vowinkel, Ferdinand Wilhelm, February 24, 1936, San Francisco.
Wheeler, Ira Abbey, January 2, 1936, Colfax.
Witherbee, Orville O., December 24, 1936, Los Angeles.
Woods, Donald Kendrick, December 10, 1936, San Diego.



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	Ninth District —Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, So-	William H. Kiger (1937), 911 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.
		Morton R. Gibbons (1938), Union Square Building, 350 Post Street, San Francisco.
		T. Henshaw Kelly (1939), 830 Medico-Dental Building, 490 Post Street, San Francisco.
		Junius B. Harris (1937), Medico-Dental Building, 1127 Eleventh Street, Sacramento.

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Editor ex officio			The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is Charles A. Dukes, the secretary is Frederick C. Warnshuis. The director of the Department of Public Relations is Frederick C. Warnshuis. The chairman of the Committee on Public Relations is ex officio a member of the Council.		
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Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

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President, S. J. McClendon, 2001 Fourth Street, San Diego.
Secretary, W. H. Newman, Medico-Dental Building, San Diego.
Meeting, *Second Tuesday, El Cortez Hotel.*

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Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.
Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

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Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

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President, Charles R. Kennedy, Bank of America Building, Paso Robles.
Secretary, E. D. Anderson, 1120 Morro Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Mulholland's Grill, San Luis Obispo.*
(Roster lists continued on advertising page 6)

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Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

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Meeting, *Second Monday, Cottage Hospital.*

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Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

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Meeting, *Second Monday.*

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Meeting, *Second Thursday.*

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Meeting, *Second Friday.*

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Meeting, *At Call of President.*

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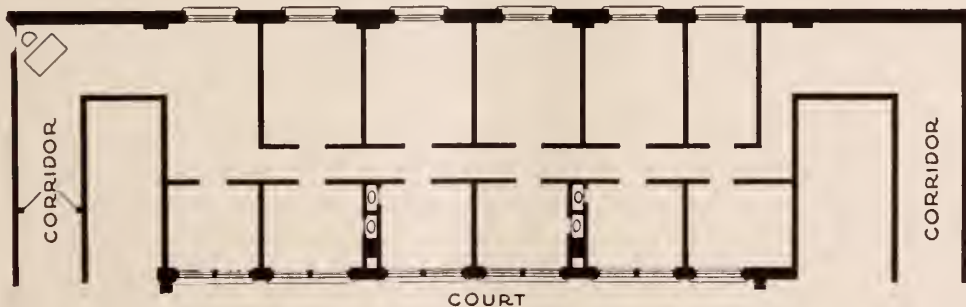


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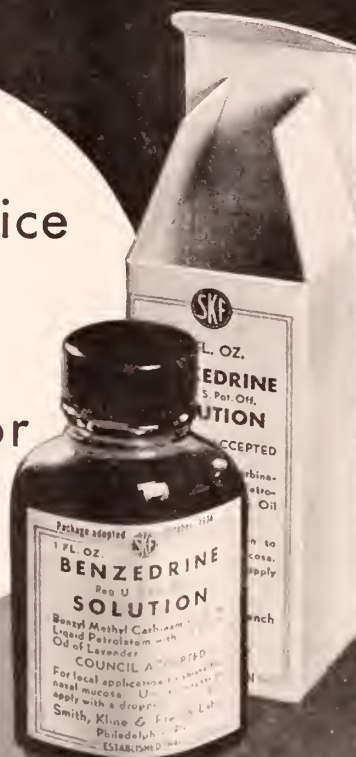
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Giordano: Penna. Med. Jour.: Oct., 1935

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—Byron

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The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

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CANYON SANATORIUM For the Treatment of Tuberculosis Redwood City, California	LAS ENCINAS SANITARIUM Nervous and General Diseases Las Encinas, Pasadena, California	SAINT FRANCIS HOSPITAL Limited General Hospital Bush and Hyde Streets, San Francisco
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COMPTON SANATORIUM AND LAS CAMPANAS HOSPITAL Neuropsychiatric and General Compton, California	OAKS SANITARIUM For Treatment of Tuberculosis Los Gatos, California	ST. MARY'S HOSPITAL General Hospital 2200 Hayes Street, San Francisco
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Rates for these insertions are \$4 for fifty words or less; additional words 5 cents each.

COACHING FOR STATE BOARDS—MEDICAL AND Dental. Arthur H. White, M. D., Suite 1005, Flood Building, San Francisco.

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BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

A Textbook of Medicine. By Charles Phillips Emerson, M. D., Research Professor of Medicine, Indiana University, Formerly Associate in Medicine and Medical Resident, Johns Hopkins University and Hospital; Assistant Professor of Medicine, Cornell University, Ithaca; Medical Superintendent, Clifton Springs Sanitarium, New York; Professor of Medicine and Dean, Indiana University School of Medicine, Indianapolis, Indiana. Cloth. Pp. 1295. Price, \$8. Philadelphia: J. B. Lippincott Company, 1936.

The Physiology and Pharmacology of the Pituitary Body. By H. B. Van Dyke, Professor of Pharmacology, Peiping Union Medical College, Peiping, China. Cloth. Pp. 577. Price, \$4.50. Chicago: The University of Chicago Press, 1936.

International Clinics. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles. By leading members of the Medical Profession Throughout the World. Edited by Louis Hamman, M. D., Visiting Physician, Johns Hopkins Hospital, Baltimore, Maryland. Volume IV, Forty-Sixth Series. Cloth. Pp. 352. Philadelphia: J. B. Lippincott Company, 1936.

Diseases of the Coronary Arteries and Cardiac Pain. Edited by Robert L. Levy, M. D., Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University; Associate Visiting Physician and Cardiologist, Presbyterian Hospital, New York City. Cloth. Pp. 445. Price, \$6. New York: The Macmillan Company, 1936.

Skin Diseases in Children. By George M. MacKee, M. D., Professor of Clinical Dermatology and Syphilology, New York Postgraduate Medical School, Columbia University, New York, and Anthony C. Cipollaro, M. D., Associate in Dermatology and Syphilology, New York Postgraduate Medical School, Columbia University, New York. Cloth. Pp. 345, with 153 illustrations. Price, \$5.50. New York: Paul B. Hoeber, Inc., 1936.

A Health Education Workbook for Teachers, Parents, Nurses, and Social Workers. By Kathleen Wilkinson Wooten, M. D., Professor of Health; Head, Department of Health and Physical Education, Georgia State College for Women, Milledgeville, Georgia. Paper. Pp. 292. Price, \$1.50. New York: A. S. Barnes & Company, 1936.

Epidemic Amebic Dysentery. The Chicago Outbreak of 1933. National Institute of Health, Bulletin No. 166. By (Continued on Next Page)

NEW MEDICAL BOOKS

Alexander: Medical Value of Psychoanalysis.....	\$3.00
Blum: Applied Dietetics.....	4.75
Diethelm: Treatment in Psychiatry.....	4.00
Menninger: Juvenile Paresis.....	3.00
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PAUL C. ALEXANDER, M. D.
Resident Physician

San Francisco Office:

516 Sutter Street

Telephone DOuglas 4486

BOOKS RECEIVED

(Continued from Preceding Page)

Board of Health of the City of Chicago. Paper. Pp. 187. Price, 20 cents. Washington: United States Government Printing Office, 1936.

Cardiovascular Disease. By Joseph H. Schrup, M. D., Dubuque, Iowa. Paper. Pp. 20. Price, 12 cents. Dubuque, Iowa: J. H. Schrup, 1936.

Plastic Surgery of the Nose. By J. Eastman Sheehan, New York. Second Edition, entirely rewritten. Cloth. Pp. 186, with 131 text illustrations, including seven in color, and fourteen full-page plates, consisting of 104 photographs. Price, \$9. New York: Paul B. Hoeber, Inc., 1936.

BOOK REVIEWS

A Dissertation on the Sensible and Irritable Parts of Animals. By Albrecht Von Haller (1708-1777). Price, \$1. Johns Hopkins Press.

This is a reprint of the memoir read by Von Haller at Göttingen in 1752.

The Practice of Medicine. By Jonathan C. Meakins, M. D., LL. D., Professor of Medicine, McGill University. Pp. 1343. Cloth. C. V. Mosby Company, St. Louis.

Meakins frankly admits that he has written this treatise on the practice of medicine for the student and the general practitioner. As a feature he has given symptoms particular prominence, claiming that they give the clues to diagnosis and the solution of clinical riddles. Another feature is the use of many illustrations, 540 of them, for the purpose of amplifying the text and imparting more informative facts.

In other respects the subject has been covered exceedingly well and with evident thoroughness. Many references are included.

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\$200,000 deposited with State of Nebraska, for our members' protection.



This treatise will be appreciated by the undergraduate and the younger practitioner, as it will lead them to acquire more complete knowledge.

Plastic Surgery of the Nose. By J. Eastman Sheehan, M. D. Second Edition. Pp. 186. Price, \$9. Paul B. Hoeber, Inc.

This is an ordinary text that sets forth what plastic surgery may do for a deformed or injured nose. The descriptive text and illustrations are largely generalizations. Detailed technique is wanting.

A Textbook of Medicine. By Charles P. Emerson, M. D., Professor of Medicine, Indiana University. Cloth. Pp. 1296. Price, \$8. J. B. Lippincott Company.

This well-known and highly regarded clinician was provided the opportunity of writing this text by reason of his appointment as research professor of medicine of the Indiana University.

The author cites four features that characterize this text: Clinical pictures of disease, biographical notes of men concerned with historical advances in medical knowledge, diseases are presented as defensive syndromes, the patient's emotional reactions, and environments.

It is a well-written text and ably presents the subjects discussed. It is a dependable text for students.

The Physiology and Pharmacology of the Pituitary Body. By H. B. Van Dyke, Professor of Pharmacology, Peiping Union Medical College. Cloth. Pp. 554. Price, \$4.50. University of Chicago Press.

This book represents an attempt to describe and evaluate our knowledge of the pituitary body in terms of physiology and pharmacology. It is not possible to state that what we know in regard to the pituitary and its functions is complete. This complex body and its hormones still holds much of mystery, hence studies and deductions such as this are received as mere progress records.

(Continued on Page 17)

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Serum treatment should be both *prompt* and *intensive*. The dosages recommended are intended to be administered within a 12-24 hour period. Antipneumococcic serum therapy is less effective when the basic dosage is spread over several days.

The death rate rises rapidly with the lapse of time from the onset of the disease to the beginning of adequate serum therapy, and the amount of serum necessary for adequate treatment increases as the disease progresses.

Cecil* has combined the reports of several authors, which demonstrate the importance of early administration:—

Type	First 4 Days		After the Fourth Day		Controls (all days)	
	Cases	Mort. %	Cases	Mort. %	Cases	Mort. %
I	744	9.6	641	23.6	565	33.6
II	362	29.6	155	38.7	516	45.3

After the fifth day in the non-bacteremic cases and the fourth day in bacteremic cases, enormous amounts of serum are needed—and the prognosis may be poor. Early and adequate therapy saves lives—and serum.

*Dr. Russell Cecil, N. Y. S. Jour. of Medicine, Vol. 35, Nov. 15, 1935, No. 22, p. 7.

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BOOK REVIEWS

(Continued from Page 14)

Bibliography is presented in 188 pages of the text. The remainder records some of our accepted physiologic and pharmacologic findings in compilation form. As such it serves as a satisfactory reference guide.

International Clinics. Vol. IV, Forty-Sixth Series. 1936. J. B. Lippincott Company.

Nineteen contributors present the articles in this volume devoted to medicine and recent progress in dermatology. The established standard of this series is maintained.

A Health Education Workbook. By Kathleen W. Wooten, Professor of Health and Physical Education, Georgia State College for Women. Paper. Pp. 273. Price, \$1.50. New York: A. S. Barnes & Co.

This workbook is an activity program and outline for the practical training of teachers, social workers, nurses, and parents. As such it will do much to encourage the practical and abolish the fads in school or community health programs.

Diseases of the Coronary Arteries and Cardiac Pain. Edited by Robert L. Levy, M. D., Columbia University. Cloth. Pp. 445. Price, \$6. The Macmillan Company.

This clinic on coronary arteries is conducted by fourteen writers. Since 1912, when Herrick directed attention to the coronary arteries, much interest and increasing attention has been given this subject. Great advances in knowledge have been made and opinions are becoming crystallized. We welcome this presentation of our present knowledge of the subject and summary of clinical experiences. The tragedy of the coronaries has cut short the careers of distinguished men in their height of usefulness. Compelling attention has been directed to these cardiac vessels, and as a result there has been a rapid accumulation of information on the subject. This text takes stock of that information and indicates the direction in which future studies of the subject should be made. It is a well-done compilation.

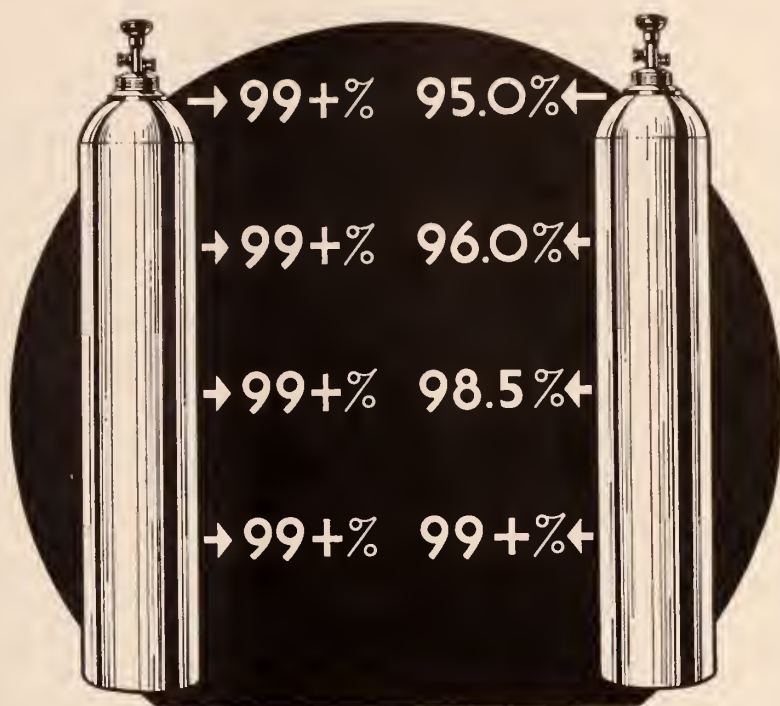
Herrick, Cohn, and Wiggers, in an advisory editorial capacity, insure the dependability of the text. Authorization is further insured by the collaboration and writings of Beck, Blumgart, Dublin, Kerr, Smith, Wearn, White, Wilson, and other acknowledged clinicians.

Each chapter is so well done that it is impossible to point to an outstanding chapter—the entire book is outstanding.

Suffice it, then, to state that no practitioner or specialist can afford to neglect obtaining this book, or to diligently read and study it. Doing so will enable the individual to acquire a true knowledge as to what is known today about coronary disease.

Skin Diseases in Children. By George M. MacKee, M. D., Columbia University, and Anthony C. Cipollaro, M. D., Columbia University. 153 illustrations. Cloth. Pp. 333. Price, \$5.50. New York: Paul B. Hoeber, Inc.

These joint authors have written a text that should be very helpful to the general practitioners. It is practical, with omission of pathological description, disputed points,



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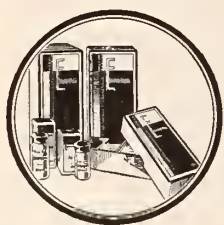
and doubtful remedies. Eruption characteristics are given in detail, differentiation is made when diagnosis is difficult. Emphasis is placed on etiology. Treatment is well outlined for the general practitioner who should with this text be able to treat well the common cutaneous lesions. This addition to our literature will find a place in the library of all progressive practitioners.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 69)

attention than anything *Collier's Weekly* or even our own *Journal of the American Medical Association* has had to offer, and since Ibsen's "Ghosts," we cannot recall anything so powerful. . . .

Dioradin Once More.—The way in which a manufacturer, who is industriously striving to promote a useless
(Continued on Next Page)



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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

remedy, is abused nowadays by some journals is enough to bring tears to the eyes of any self-respecting crocodile! Were we but crocodiles we would weep most copiously (with apologies to Chimmie Fadden). All of which is but a painful part of the turgid feelings aroused by reading a circular from the "Dioradin Company," addressed "To the Physicians of California," and subheaded "Dr. Max Rothchild's Disgraceful Editorial." . . .

Salvarsan—A Warning.— . . . The important point is this: A good, sensible view of salvarsan should be taken by the physician. It should be considered preëminently as a symptomatic treatment and a marvelous one, and not as a cure-all. Let us not dispense with the time-honored remedies, which are so necessary and which so frequently act far better after the use of the arsenic.

Medical Defense.—No criticism of the practices of liability insurance companies has been uttered by the State Society or voiced by the Journal at any time since we, as a society, undertook the coöperative defense of our members in alleged malpractice suits. Some of them are mightily open to criticism, however. (In passing let it be noted that the defense has won every suit defended by the State Society since the work began.) . . .

Public Health and Its Foes.—The introduction into Congress of a bill by Senator Owen to create a department of public health, a few years ago, aroused immediate opposition from certain questionable sources. The same interests which had opposed the Pure Food and Drugs Act, opposed this bill; and probably for similar reasons. But this time they were more open in their opposition. They organized what they were pleased to call the "League for Medical Freedom," made a loud cry about

the "doctors' trust" and assailed the medical profession and the American Medical Association. . . .

The Los Angeles County Medical Association quite naturally resented the reflections cast upon those physicians in Los Angeles (Senator Works' home) who had attended him, and wrote to the Senator on the subject. Considerable correspondence resulted, and all of this, together with a valuable mass of related material, has been published in Bulletin No. 22 of the Los Angeles County Medical Association. We understand from the secretary, Dr. George H. Kress of Los Angeles, that a copy of this Bulletin has been sent to every physician in the State. If you have not received one, or if you desire others, you can secure copies from Doctor Kress. It is unfortunate that the matter contained in this little document cannot be placed in the hands of laymen, for it is the ordinary citizen who is to settle this question in the end. . . .

From an article on "Report of a Case of Polycythemia" by William C. Voorsanger, M. D., San Francisco.

Polycythemia was first described in 1892 by Rendu and Widal, with two salient features:

1. Chronic cyanosis due to polycythemia.
2. Splenic enlargement.

These authors attributed this symptom complex to a splenic tuberculosis. Vaquez in 1899, Turk in 1902, and Osler in 1903, called general attention to the above syndrome, demonstrating that it was not due to splenic tuberculosis, but to a primary hyperplasia of the erythroblastic bone marrow. . . .

From an article on "Analysis of Treatment of Sixty-Two Cases of Syphilis with Salvarsan" by Louis Gross, M. D., and Walter S. Johnson, M. D., San Francisco.

When salvarsan was ushered into syphilitic therapeutics, it was heralded as a great cure-all, assuming a responsibility no other drug ever had to contend with. The fact

(Continued on Page 22)

CONSERVATION OF ESSENTIAL ELEMENTS IN PROTECTIVE FOODS

I. MINERALS

● Considerable differences may exist between the mineral contents of foods from both the qualitative and quantitative standpoints. In fact, variation in mineral content has been noted even in the same plant variety; such variations being dependent, among other factors, upon soil or climatic conditions (1).

A striking example of the influence of one of these factors is the relative richness in iodine of field crops raised in certain coastal regions of this country where the soil is also high in iodine.

From the point of view of those concerned with human nutrition, interest in the mineral content of the food supply is usually centered around calcium, iron and iodine; since it is generally agreed that of all the essential minerals, these are the ones most apt to be inadequately supplied by the average varied diet. Conservation of these minerals in foods is, therefore, a matter of considerable practical interest.

Unlike the vitamins, minerals are not lost during storage of fruits and vegetables. However, solution losses during cooking may be severe, due to the fact that most minerals, as they occur in the plant, are soluble, or at least are extractable, by the water in which they are cooked. For example, cabbage cooked by the usual home method has been shown to lose from 21 to

72 per cent of its calcium (2).

As exemplified by these studies, solution losses of minerals in leafy vegetables are usually high. Losses in vegetables as a class are not, however, so excessive, as indicated by an average reported loss of 19.5 per cent of the calcium in seven common vegetables (3).

The average decrease during cooking in the ash content of five common vegetables has been found to approximate 37 per cent (4).

While the extent of mineral loss during ordinary home cooking methods will vary with the particular element under consideration as well as the food in which it is contained, sufficient evidence is at hand to indicate that such losses may be considerable. It is further apparent that discarding the cooking water—the usual home practice—entails a loss of valuable, essential mineral components of food.

Modern practice in commercial canning goes far in preventing these solution losses of minerals. Canned foods are cooked by the heat process accorded them while still contained within the hermetically sealed can. A minimum of water is used which also remains within the can, conserving for the consumer's use those extractable essential mineral elements which may be lost to the cooking water during home preparation of market varieties of foods.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1936 J. Nutrition 11, 55.

(2) 1936 J. Home Econ. 28, 18.
1925 Ibid, 17, 265

(3) 1935 J. Home Econ. 27, 376
(4) 1917 Amer. J. Dis. Child, 14, 34

This is the twentieth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.



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THE LIFE SPAN of the diabetic has been lengthened considerably following the discovery of Insulin and the growing knowledge of its use. There is, however, a definite responsibility on the part of the physician to educate the many new diabetics in the importance of proper diet and proper use of Insulin.

The apparent increase in diabetes in recent years has been attributed to the modern manner of living, increased sugar consumption, overeating and lack of muscular exercise. With proper management the great majority of these patients can be kept well-

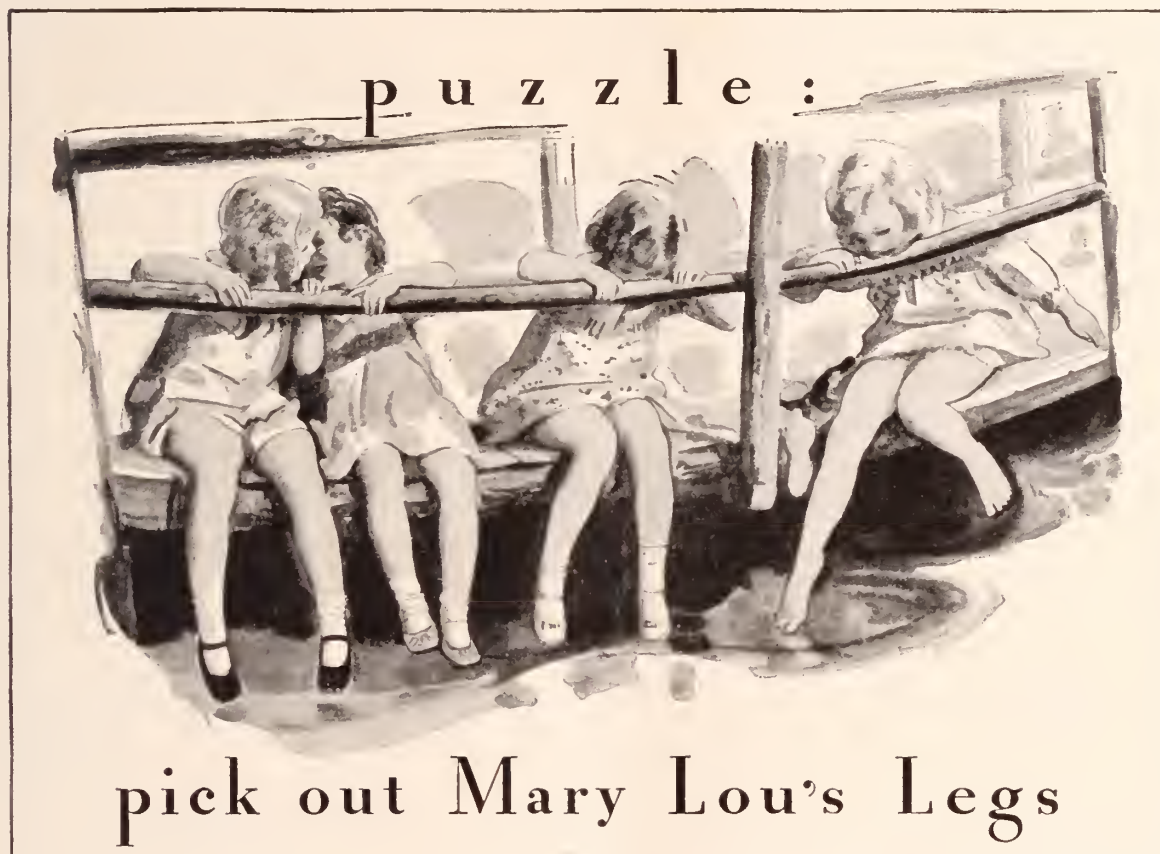
nourished, sugar-free and at work.

When Insulin therapy becomes necessary, Insulin Squibb may well be a product of choice. Insulin Squibb is highly purified, highly stable and remarkably free from proteinous, reaction-producing substances. Great care is taken in its assay to make it uniformly potent. More physicians and more patients are using Insulin Squibb than ever before. They rely upon the quality and dependability of this Squibb Product.

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Fewer children with iron braces! More children with legs as straight and handsome as young saplings! Fewer hollow chests! More well-shaped jaws and pleasing little profiles! *These are some of the advantages which modern developments in vitamin medication—especially vitamins A and D—have made possible.*

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

that it has withstood for almost a year all onslaughts, proclaims it as a wonderful preparation.

In this series of sixty-two cases we have aimed to place our material before you in a clear and concise manner. We have controlled our cases with Wassermann tests, and in over half of the cases with Noguchi also. . . .

From an article on "Multiple Papillomata of the Larynx in Children—Report of Two Cases," by E. C. Sewall, M.D., San Francisco.

I wish to report two cases which have come under my care in the past few years, first because of their comparative rarity and, second, because of the ease with which the latter case was handled as compared with the former due to the improvement in technique which a very short time has brought to our aid. . . .

From an article on "Hospital Department—San Francisco Hospitals," by William R. Dorr, M.D., San Francisco.

Perhaps no other city in history, and certainly no other modern city, has had more incentive to construct and put in running order a large number of hospitals than San Francisco has had during the last five years, and I am sure that no community could have responded more loyally to the need than has been done during this more or less trying period.

In the spring of 1906 San Francisco had about forty hospitals, of which very few could be described as thoroughly modern and up to date. . . . After the great conflagration only four hospitals remained that were housed in modern buildings built for hospital purposes and few of the old structures remained, so that hospital authorities

were pushed to the utmost to provide temporary makeshifts to fill the need for hospital treatment.

It was not long, however, before plans were being adequately made to fill the need, so that today we have a large number of hospitals, all of which are modern and up to date in every way, that have been built for hospital purposes and have all been completed or started during the last five years. . . .

From an article on "Selected Chapters in the Study of Speech Disturbances, No. 2—The Responsibility of the General Practitioner to the Child with a Speech Defect, with Suggestions as to Prophylactics," by Henry Horn, M.D., San Francisco.

It is beginning to be believed that the day of the general practitioner is departing and that the specialist is usurping the throne of the old family physician. No better refutation of this fact is needed than to observe the rapacious appetite of the general practitioner for special knowledge. It is the specialist who is being forced back into the ranks of the generalist by the tremendous border-line studies that are having a vast influence on his own narrow specialty. . . .

From an article on "Mechanical Efficiency" by James T. Watkins, M.D., San Francisco.

The purpose of the group of lectures, of which this is one, is to give you some insight into the art or, as it is fast becoming, the science of right living; right living especially as it applies to yourselves and to your charges. In my own lecture I shall briefly direct your attention, first, to what we have come to regard as the state of maximum efficiency of the human body. I shall then dwell upon conditions which are essential to this state of well-being. Finally, I shall discuss some of the commoner causes of physical inefficiency. Such a study is peculiarly the function of that branch of the healing art called orthopedic surgery. . . .

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The "Prevention of Sexual Diseases." By Victor C. Vecki, M. D., with introduction by William J. Robinson, M. D., 12 Mount Morris Park W., New York, 1910.

The synoptical plan followed by the author in the little work before us detracts in nowise from the frank and wholesome breeziness of his treatment of the subject-matter. He has condensed in most cogent and interesting form practically the substance of the most mature views on this vital and hitherto usually glossed-over phase of social life. No attempt has been made to benumb the mind with a mass of indigestible statistics; or make mawkish appeal to the sensibilities through the recital of harrowing case histories. The time and the opportunity for the dissemination of wholesome and unglossed truths regarding the consequences of the disobedience of the laws of sex hygiene have long awaited fearless propagandists. The author is one of the first to come into the open with commendable directness and vigor. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 69)

Five members of the ring are fugitives, and bench warrants were issued for them several weeks ago." (San Francisco Chronicle, November 24, 1936.)

"Five members of a coast-wide illegal operations ring yesterday were given suspended sentences and placed on five years' probation by Superior Judge Arthur Crum. Violet Pelligrini, a nurse, was sentenced to one year in the county jail as a part of her probation. Lillian Wilson and Grace Moore, receptionists, were ordered to spend six months of their probation period in the county jail. J. C. Shinn and John Creeth, clerks in the office of the Medical Acceptance Corporation, were placed on probation without jail terms." (Los Angeles Examiner, November 17, 1936.)

"Only Mexican citizens will be allowed to practice medicine, law, dentistry or other professions in the southern republic if proposed legislation is adopted, the Associated Press reported yesterday from Mexico, D. F. Statutes are being prepared, the report stated, to require all professional people in Mexico to take out naturalization papers. This probably would end the practice of San Diego physicians and dentists, who are frequently called to Tijuana, Mexicali, and Ensenada to attend clinics and perform operations, Louis Castro, Mexican Consul here, said. . . ." (San Diego Union, November 8, 1936.) Note: A letter recently received from a Japanese physician licensed in this State, now visiting in Japan, related that similar regulations are in force in Japan.

"Conviction of two Los Angeles physicians on charges of illegal sale of morphin was upheld yesterday by the United States Circuit Court of Appeals, sitting at San Francisco. The doctors, F. T. Cary and E. H. Williams, were sentenced December 3, 1934. This means that Doctor Cary will have to serve a year in a road camp. Doctor Williams was placed on two years' probation. 'This is the first decision of its kind on the Pacific Coast and is expected to have far-reaching results,' it was announced last night by Assistant U. S. Attorney Jack Irwin, one of the prosecuting attorneys. 'In the past it has been possible for persons to delay the execution of their sentences indefinitely. A ruling of the United States Supreme Court in September, 1934, is now in effect, expediting criminal appeals and eliminating delays.' Doctor Williams and Doctor Carey were convicted on charges of conspiracy to issue narcotic prescriptions unlawfully. Doctor Williams had served without salary as a member of the city narcotic staff for many years." (Los Angeles Illustrated Daily News, November 17, 1936.)

"E. B. Hartman, former San Bernardino chiropractor, is making a final move to avoid serving 180 days in the
(Continued on Next Page)

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The Cottage Department (for mental patients) has its own facilities for hydropathic and other treatments. It consists of small cottages with homelike surroundings, permitting the segregation of patients in accordance with the type of psychosis. Also bungalows for individual patients, offering the highest class of accommodation with privacy and comfort.

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

county jail by filing a petition for a writ of habeas corpus with the State Supreme Court at San Francisco, it was learned today. Hartman was convicted on two charges of violating the State Medical Act and sentenced by Justice Russell A. Wickizer to serve 180 days on one count and ninety days on the other, the terms to run concurrently. . . . Hartman was convicted of practicing medicine without a State license and unlawful use of the prefix 'Dr.' His chiropractor's license was revoked after his conviction." (Ontario Report, November 27, 1936.)

"Accused of performing an illegal operation that resulted in a white girl's death, Dr. Jack Smitherman, forty-seven, negro, 215 East Forty-fifth Street, was arrested yesterday on suspicion of murder and suspicion of performing the operation. Virginia Sandefur, twenty-one, died in Huntington Park Hospital allegedly as the result of an operation the negro physician performed." (Los Angeles Daily News, December 7, 1936.)

"With his bond reduced from \$50,000 to \$5,000, Dr. Jack Smitherman, negro physician charged with malpractice which assertedly resulted in the recent death of a white woman, Mrs. Virginia Sandefur, yesterday gained his release from the county jail. He is to appear December 21 for preliminary hearing before Municipal Judge Benjamin J. Scheinman." (Los Angeles Examiner, December 15, 1936.)

"At the request of the District Attorney's office, charges of murder and malpractice against Dr. Jack Smitherman, negro, yesterday were dismissed by Municipal Judge Benjamin J. Scheinman. . . ." (Los Angeles Examiner, December 17, 1936.)

"Pleading guilty to a charge of selling useless medicine under a violation of the California Pure Drug Act, Dr.

James Decker, osteopath, of 5729 Shafter Avenue, was sentenced to \$25 fine and 180 days' probation yesterday by Police Judge Chris Fox in Oakland. He was arrested by C. B. Heizer, inspector for the State Department of Public Health." (San Francisco Examiner, East Bay Edition, December 16, 1936.)

"A murder charge against Mrs. Regina Holscher, fifty-eight, of 3425 Larissa Drive, was ordered dismissed today by Superior Judge Fricke after the woman pleaded guilty to having performed an illegal operation on Mrs. Hazel Scott, forty-one, of 4129 Tujunga Street, Burbank, who died last August 28 at General Hospital. Mrs. Scott's death was listed in the hospital records as having been caused by pneumonia. The coroner's office report said the operation was a contributing cause of death. Mrs. Holscher applied for probation on the operation charge, and Judge Fricke set December 18 as the date for the hearing of the motion." (Los Angeles Herald-Express, December 3, 1936.)

"Sixty days in the city jail was prescribed yesterday in Municipal Court for Alex F. Pena, on the charge that Pena illegally posed as a doctor. Pena already was an inmate of the jail, following his plea of guilty to a charge of petty theft from Lupe Castellon. She charged she went to his Main Street offices for a treatment and that when she gave him \$10 he went out to change the bill and never returned. 'If you have got it, I can cure it,' the business card bearing 'Dr.' Pena's name stated, the Court was told. The card recently came into the hands of John R. Ronan, investigator for the State Board of Medical Examiners." (Los Angeles Examiner, December 9, 1936.)

"Dr. George W. O'Donnell of San Francisco, whose license to practice medicine in California was revoked last October by the State Board of Medical Examiners, yesterday filed a petition in the Superior Court for a writ of

(Continued on Page 26)

Old Way...

CURING RICKETS in the CLEFT of an ASH TREE

FOR many centuries,—and apparently down to the present time, even in this country—ricketic children have been passed through a cleft ash tree to cure them of their rickets, and thenceforth a sympathetic relationship was supposed to exist between them and the tree.

Frazer* states that the ordinary mode of effecting the cure is to split a young ash sapling longitudinally for a few feet and pass the child, naked, either three times or three times three through the fissure at sunrise. In the West of England, it is said the passage must be "against the sun." As soon as the ceremony is performed, the tree is bound tightly up and the fissure plastered over with mud or clay. The belief is that just as the cleft in the tree will be healed, so the child's body will be healed, but that if the rift in the tree remains open, the deformity in the child will remain, too, and if the tree were to die, the death of the child would surely follow.

*Frazer, J. G.: *The Golden Bough*, vol. 1, New York, Macmillan & Co., 1928



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

New Way...

Preventing and Curing Rickets with OLEUM PERCOMORPHUM

NOWADAYS, the physician has at his command, Mead's Oleum Percomorphum, a natural vitamin D product which actually prevents and cures rickets, when given in proper dosage.

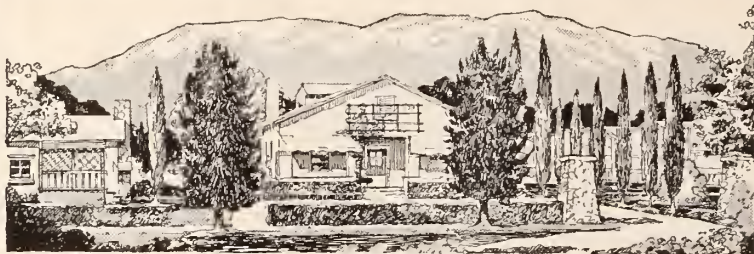
Like other specifics for other diseases, larger dosage may be required for extreme cases. It is safe to say that when used in the indicated dosage, Mead's Oleum Percomorphum is a specific in almost all cases of rickets,

regardless of degree and duration. Mead's Oleum Percomorphum because of its high vitamins A and D content is also useful in deficiency conditions such as tetany, osteomalacia and xerophthalmia.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 24)

review. The petitioner contends there was no evidence offered at the hearing before the State Board to bear out the Board members' contention he performed an illegal operation upon Mrs. Blanche LaBerta Miller of San Francisco. Doctor O'Donnell denies performing the operation, declaring that he merely prescribed normal medical treatment for the woman." (Sacramento *Bee*, November 10, 1936.)

"Bench warrants for five persons allegedly connected with the state-wide abortion ring, were issued yesterday by Superior Judge George Steiger. The five named in the bench warrants were: Dr. H. L. Houston, Mrs. Ruth Hanson, Viola Warner, Bess McCarthy, and Beatrice Bole. . . ." (San Francisco *Examiner*, November 24, 1936.)

"City Attorney Claude Rowe informed the City Commission by letter today, through Finance Commissioner William Glass, that osteopaths and chiropractors are not

entitled under the city ordinance to obtain emblems for their automobiles which entitle the owner of the car to certain police privileges. Rowe said the emblem can be given only to physicians and surgeons licensed under the State Board of Medical Examiners. The Commission gave the osteopaths and chiropractors a week to answer before taking action." (Fresno *Bee and Republican*, November 27, 1936.)

Recent correspondence with H. F. Hudson, attorney-at-law, Wichita, Kansas, indicates he has brought legal action on behalf of a client against one Thomas J. Libbin, Los Angeles, who, Attorney Hudson claims, calls himself a psycho-analyst. No such individual is licensed to practice any system of the healing art in the State of California. Mr. Hudson claims that during the period April 18, 1928 to June 2, 1932, his client (then a resident of Los Angeles) paid Libbin \$7,332.50, "mostly at the rate of \$10 per hour. In addition, he also got two notes out of her for the sum of \$1,000. Instead of being satisfied with the \$7,332.50, he had the gall to sue her on the notes and when he did I slapped a counterclaim on him, in which I seek to get a judgment of \$7,332.50 and cancel

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the two notes on the ground of fraud, duress and undue influence. . . ."

"Former Policeman John C. Farrell, who resigned while facing a second trial on a charge of robbing a Shumate drug store, and Dr. Nathan S. Housman, mentioned in the Frank J. Egan murder trial, were sued today for money assertedly taken from a dying man. Two others, Attorneys John J. Taaffe and George B. Harrison, also were named in the conversion action filed by Mrs. Mignon W. Baker of Los Angeles, widow of Louis M. Baker. . . . Mrs. Baker's complaint, filed by Attorneys Levin and Herbert A. Leland, charges that when her husband was injured (in a Peninsula automobile accident) he had in his possession \$9,874.14. He was taken to a hospital and the hospital deposited the money in a bank to Baker's credit. Then, according to Attorneys Levin and Leland, Farrell

(Continued on Next Page)

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★ Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

came into the picture. He allegedly got an order signed by the dying Baker, authorizing him to withdraw the money from the bank. It is charged that Farrell paid Doctor Housman \$6,100 for his alleged services; however, two noted brain specialists were called into the case and were paid only \$600. This latter charge is not disputed. Farrell also is charged with having paid Attorney Taaffe and Harris a 'legal fee' of \$1,250 out of Baker's money. According to Mrs. Baker, \$1,394.60 of the original \$9,874.14 was spent legitimately on funeral expenses and hospital costs. She demands return of \$8,479.54, plus cost of suit, including \$2,500 attorneys' fees. Russell Sweet, football coach at San Francisco Junior College, recently sued Frank Baker, alleged driver of the car that struck his machine, killing his wife, for \$75,000 for her death and \$25,000 for his own injuries." (San Francisco Call-Bulletin, December 1, 1936.)

The records of the Board of Medical Examiners show recent correspondence regarding an individual known as Clyde E. Tillotson, who, according to reports, was formerly employed by the Federal Government as a physician in a C. C. C. camp near Fresno. On October 1 he was reported as held in the San Diego county jail, and his picture, forwarded by San Diego County Sheriff, shows him to be No. 55093, held, we understand, on a charge of impersonating a federal officer. Report also relates that a complaint has been filed and a warrant issued charging him with violation of the Medical Practice Act. According to the Federal Bureau of Investigation, J. E. Hoover, Director, Washington, D. C., Clyde Tillotson has been involved in legal difficulties in Des Moines, Iowa (bigamy); Ottumwa, Iowa (bad check); San Diego, No. 11186 (August 27, 1936, drunk, impersonating federal officer); San Diego, No. 55093, August 31, 1936, "Section 76, Title 18, U. S. C." Headquarters, Fresno District, Civilian

APPROVED CLINICAL PATHOLOGISTS

American Medical Association Essentials for An Approved Clinical Pathologist

An approved clinical pathologist should be a licensed graduate of medicine. He shall have specialized in clinical pathology, bacteriology, pathology, chemistry, and other allied subjects for at least three years, and he should be reasonably familiar with the manifestations of disease in the body. The director of a clinical laboratory shall be on full time or have definite hours of attendance, devoting the major part of his time to this specialty. A clinical laboratory is an institution organized for the practical application of the fundamental sciences by the use of specialized apparatus, equipment and methods, for the purpose of ascertaining the presence, nature, source, and progress of disease in the human body.

The following Clinical Pathologists directing private laboratories in California are approved by the Council on Medical Education and Hospitals of the American Medical Association:

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Conservation Corps, on September 14 related that "Doctor Tillotson was engaged as a contract surgeon in this district on January 18, 1936. . . . The diagnoses of medical and dental cases transferred for treatment to the Fresno District Dispensary by Doctor Tillotson were erroneous, except in one instance. . . . Doctor Tillotson was relieved on June 30, 1936, because of the above continued deficiencies."

"The most contemptible of all rackets are those whose victims are the aged and sick; hence it is most welcome news that the Federal Government has stepped into the fake eyeglass and medical racket and put seventeen of its leading fakers under arrest. These men went around the country selling dime-store eyeglasses for prices up to \$100 or more. Then a follow-up man would come in, assure the unfortunate dupe that he or she needed an immediate 'operation' to correct the trouble produced by the glasses and get from \$500 to \$1,000 for a fake operation. These

miscreants, of course, should be jailed for as long a time as the law allows. That, however, will not put an end to such racketeering. People must learn, when they suffer from physical ailments, to consult only qualified, licensed and reputable physicians, dentists, optometrists, etc., who have permanent residences and place of business and, therefore, are responsible. If everyone would adhere to that simple and wholly reasonable principle of action, the quack and the medical racketeer automatically would go out of business." (Editorial, *Sacramento Bee*, October 12, 1936.)

Report from the Southern Investigation Department relates that Clifford Pickett on November 24, 1936, pleaded guilty in the courts of Los Angeles to a charge of violation of the Medical Practice Act and on December 1 was sentenced to serve 180 days in the city jail, sentence being suspended and defendant placed on probation for two years.

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FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$_____, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

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FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reimburse the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the _____ Gift, the following described real property situate in the County of _____, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

Bovine Tuberculosis.—Still true is the statement that there are more tuberculous cattle in California than in any other state. Due to the efforts of the State Department of Agriculture and the health workers of the State, progress is being made in the eradication of this disease. Imperial County is now included in the nine counties having a herd infection of less than 0.5 per cent.

The present status of the eradication control areas in California is:

Counties	Cattle Infected
9.....	Less than 0.5 per cent
5.....	Less than 1 per cent
32.....	From 1 to 3 per cent, inclusive
3.....	From 4 to 7 per cent, inclusive
5.....	From 8 to 15 per cent, inclusive
4.....	Over 15 per cent

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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Address editorial communications to Dr. George H. Kress as per address above; advertising and business communications to Secretary-Treasurer, Dr. Frederick C. Warnshuis, also at above address.

EDITOR GEORGE H. KRESS

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Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles; Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

THE 1937 LEGISLATURE IS IN SESSION

The Legislative Calendar.—The biennial session of the California Legislature, which began on Monday, January 4, will hold daily meetings up to February 1 to permit submittal of proposed laws; after which it will adjourn for thirty days to allow the assemblymen and senators to return to their homes for study and discussion of legislative matters, when both houses will reconvene on March 2, to continue the session until final adjournment, probably in May or June.

* * *

The Onerous Task of the Committee on Public Policy and Legislation.—What kind of contemplated statutes affecting public health interests will be thrown into the legislative hopper during the January meetings no one can foretell with accuracy; but there need be little doubt, in days of such social unrest as these, that new and even startling types of laws will be suggested.

In past legislative sessions, proposed measures having to do with public health matters usually were numbered, not by ones or tens, but by hundreds. The task of the Association's Committee on Public Policy and Legislation, therefore, is made doubly onerous because almost every bill introduced, no matter how innocent its title or seeming purport, must be carefully read—both at its introduction and later in course through committees—to make certain that no provisions inimical to the public health interests of the State are included. What such responsibility means to those upon whose shoulders this heavy duty has been thrust, is well understood by members of the Council; but as to members of the California Medical Association, in general (more than five thousand in number), it is a question whether many are likewise alert to the great labor involved.

* * *

How Component County Societies Can Aid. It is hoped, then, that the officers of the component county societies and the delegated local committees on legislation will maintain an active interest throughout the entire legislative session, respond-

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column, which follows.

ing promptly when called upon for definite tasks; and that they will be especially active during the February intermission, in reestablishing cordial relationships with both senators and assemblymen representing their localities. To this end, the Association will aim, through bulletins, to keep component county societies informed concerning each important matter.

* * *

Some Probable Proposed Laws.—"Old and new friends" which, in all probability, will thus be dropped into the legislative basket, in more or less revised form, include measures such as

- Compulsory Health Insurance;
- Voluntary Health Insurance;
- Opening County Hospitals to Pay Patients;
- Opening County Hospitals to Non-Indigent Patients (without pay);
- Compulsory Hospitalization;
- Voluntary Hospitalization;
- Antivivisection bills;
- New Cultist Healing Art Board or Boards;
- Amendments to Medical Practice Act;
- New Nurses' Examining Board; and
- Amendments to Numerous State Public Health Laws.

The above brief list of law proposals quite possible should indicate why every physician who desires to see the standards of scientific medicine maintained and promoted should attend the meetings of his county society during the next several months, to hear reports as to progress on legislation, and also to enable him to aid his officers and colleagues in the work ahead.

In next month's issue a digest of some of the more important bills will be presented. In the meantime, alertness and cooperation on all sides should be in evidence.

INDIGENT CAMPS IN CALIFORNIA: A NEW AND PRESSING PROBLEM

California's Lure to Indigents and Near-Indigents.—The varied climatic attractions and agricultural and other interests of California for years have brought within its borders an unusually large number of individuals, from many states, belonging to the indigents or near-like aggregations; who, on account of the conditions under which they join with one another in groups, and their manner of living, have come to present rather a serious social and sanitary problem. During travel of any extent, by train or auto, for example, one is almost certain to see by the wayside such migratory bands; so that to members of the medical profession, accustomed to sober thought, serious misgivings must arise concerning the extent to which such nomadic persons endeavor to observe laws having to do with the protection of water supplies, and other important sanitary matters.

In agricultural districts, where ripened crops demand manual attention, many of these itinerant near-indigents find temporary abiding places, some

indeed making regular tours from one district to another, as different crops reach maturity. This mode of living is more or less haphazard; yet to a large number of persons of such roving disposition this life in the open evidently has a strong appeal. At times, these hither-and-thither men organize among themselves, subletting their group to individuals who, in turn, make it a business to supply agricultural districts with man-power (occasionally women and children as well as men) to harvest the crops of fruit, cotton, beans or other products of the soil.

* * *

Conditions Which Exist in Some Camps.—Housing arrangements for such transient laborers rarely measure up to proper sanitary standards; and, as a matter of fact, regarding the preparation of food, protection of drinking water and utensils, provision of cots or beds that are free from vermin, sanitary toilet facilities, and an inspection or examination of the persons themselves, to facilitate segregation of those who have communicable diseases, recent investigations indicate that conditions are often little short of deplorable.

* * *

Problem Has Been Presented to California Medical Association Council.—This increasing menace from camps of persons so grouped together, and perhaps doing little or no labor has led the California State Board of Health to institute measures for better supervision of such unofficial camps, to the end that the campers, and also the public in near-by communities, may be better protected. To inaugurate proper sanitation necessitates a certain amount of paternalistic medicine, not only of a preventive but a curative type; and because of that fact, the State Health Board's plans of procedure were some time ago outlined to the Council by its president, Dr. Howard Morrow.* Since the public county hospitals are open only to persons who have been residents in California for one or more years, these indigents are not eligible to admission there, and the question therefore immediately and naturally arises, "Who, then, shall care for these roving strangers?"

* * *

Component County Societies Invited to Aid. The Federal government is cooperating with the State in trying to work out a solution of the problem, and it is hoped that the component county societies in the districts involved will likewise see their way clear to work hand in hand with the representatives of the State Board of Health, for protection of local health interests, and to make unnecessary the inauguration of measures partaking of the nature of state medicine. County societies and members who are interested are invited to communicate with the State Director of Public Health,[†] regarding a betterment of the

* See CALIFORNIA AND WESTERN MEDICINE, December, 1936: Council minutes, item 6, page 503.

† The address of the State Director in the San Francisco office of the Board is printed under "Miscellaneous California Medical Organizations," on advertising page 6.

local conditions discussed, in so far, at least, as they may have come under their observation, and any practical suggestions will be welcome.

* * *

A Case in Point: Proposed State Law.—The extent to which this problem has already been called to the attention of lay organizations may be appreciated by mention of a communication which came to us from an attaché of the Los Angeles City Health Department only two days previous to this writing. This physician, a woman, telephoned for information on the subject, being desirous of knowing more particularly whether the supervision of these camps should be under the California Department of Public Welfare or the California State Board of Health, and stating that, at a club meeting which she attended, a resolution was presented to have this sanitary problem placed under the Department of Public Welfare through statutes to be submitted to the legislature, which is now in session. On her motion, action on the resolution was postponed until the next meeting, to permit her to secure more information.

We have here an example of how bodies of laymen become intimately identified with work in preventive and curative medicine, when physicians fail to be alert in the solution of public health problems. Each such foothold by nonmedical interests, in matters medical, makes a firmer foundation for propaganda efforts in behalf of state medicine. The duty of the organized profession in these premises would therefore seem to be quite plain, and it is hoped that each component county society, through a proper committee, will actively participate in all reasonable measures to advance a solution of the problems involved.

THE FIGHT AGAINST SYPHILIS: LONG-DELAYED, BUT OFF ON A GOOD START

The Incidence of Syphilis.—Syphilis, a disease afflicting about 5 per cent of American citizens (about one adult in ten being infected during his or her lifetime), and estimated by the United States Public Health Service to have 683,000 victims in the Union who are under constant medical care, bids fair at last to lose part of its prestige as one of the "captains of the men of death," represented by the five dread horsemen—heart disease, cancer, pneumonia, tuberculosis, and syphilis.

* * *

Surgeon-General Parran's Campaign Against Syphilis.—Substantiation for this statement rests largely upon the assumption that the efforts of Surgeon-General Thomas Parran of the Federal Health Service—to educate the American people and the American press to speak openly of syphilis as a public health menace that should and must be overcome—will be successful.

If Doctor Parran's campaign against syphilis were limited to his own writings in lay publications or official bulletins, we would not be optimistic enough to make the above statement. The

two new factors that give hope of a happy outcome are, first, that the time is ripe for a well-organized campaign against the disease; and, second, the federal Social Security Act will make available for the promotion of state and local health service for the next twelve-month period the sum of eight million dollars, a goodly portion of which can be allocated to the work in which Surgeon-General Parran, who for ten years was chief of the Division of Venereal Diseases of the United States Public Health Service, is so greatly interested.

* * *

The Strong Support in the Fight.—An educational campaign, sponsored by the national government, acting through the state boards of health, and ramifying down through local health agencies as represented in county and city health departments, and with ample financial means to inaugurate and demonstrate the value of scientific clinical procedures, is a something quite different from that of previous random onslaughts against lues.

* * *

Fracastoro's Contribution.*—The introduction of the word, "syphilis," brought into being by Fracastoro, the astronomer-medical scientist-humanitarian (1478-1553*), is not without romance. In the year 1530 he printed the medical poem, entitled *Syphilidis sive de Morbo Gallico*, so calling a mythical sheep herder who supposedly became the first victim of the dread disease, because he had defied Apollo during a long drought; and now the name of the fictitious shepherd is that of the dread scourge, although it must be assumed that the exact origin of the malady is still unknown.

* * *

Other Theories of the Origin of Syphilis.—The soldiers of King Charles VIII of France defeated themselves in their Italian Campaign (1493) by becoming victims of the disease, wherefore the Italians call it the French disease, and the French, in retaliation, referred to it as the Neapolitan disease; while others, because of the return of Columbus from America at that time, attributed the scourge to "Lo, the poor Indian." All of which supposed origins, however, are probably in error. But whatever may have been the beginning, there can be little doubt that among the white race, during the last four centuries, the family tree of practically every human being has been more or less tainted by syphilis (explaining, perhaps, why the lesions of the present day are less destructive and horrible than those depicted several centuries ago).

* * *

Pioneer Work of the American Social Hygiene Association: Director William F. Snow, Formerly of California.—One of the agencies to which much credit must be given for consistent and effective pioneer work against syphilis is the

* See articles on Fracastoro in *CALIFORNIA AND WESTERN MEDICINE*: October, 1930, page 739, and November, 1931, page 467.

American Social Hygiene Association, of which a former and beloved director of the California State Board of Health, Dr. William F. Snow, has long been general director. It was Doctor Snow, also, who gave earnest support to the legislative appropriation for a survey of tuberculosis in California, the State Commission's report resulting in the establishment of the Bureau of Tuberculosis of the California State Board of Health, providing as well for state subsidies to counties, out of which have come county sanatoria nowhere surpassed in the United States.

* * *

The Lesson to Be Learned from the Fight Against Tuberculosis.—There may be those who are pessimistic concerning the outcome of the fight against syphilis. For such, reference need only be made to the federal death rate reductions for that other dread malady, tuberculosis, from 201 per 100,000 population in 1900 to 71 per 100,000 population in 1935. In California, a considerable number of physicians who were key-men in the struggle against that disease are still in practice. As late as almost up to the year 1910, one of the large daily newspapers of Los Angeles refused to print articles with the word "tuberculosis," sent in by the Southern California Association for the Study and Prevention of Tuberculosis (the eighth antituberculosis society to be organized in the United States); so that, pitiable though it is to have to admit, such euphemisms and elegant refinements as the "great white plague" were necessary to secure space in its columns.

This experience, when coupled with the lowered death rate and other phenomenal progress made against tuberculosis the last twenty-five years, should be reassuring to those who now take up the gage of battle to carry on a similar propaganda against an equally malignant disease—syphilis. If well-considered action and plans are joined with diplomatic firmness, it will not be long before the national and local broadcasting stations (guilty of so much atrocious and dangerous misinformation sent out over the air by clients promoting medical frauds at the expense of an unsuspecting public) will modify their rules that the "offensive word" syphilis, shall not pass on their sound waves. So, also, will one newspaper after the other, in good and not far-distant time, also revoke the rule not to print the word syphilis or accept news items on the subject.

* * *

A Very Recent Experience.—In this connection it may be of interest to state that at Los Angeles on December 19, 1936, was formed the Southern California Association for the Study and Prevention of Syphilis and Gonorrhea. It was a tribute to the intelligence and earnestness of the large lay group of clubwomen who were present to take part in the organization of the society, that they urged an abatement of the hush-hush policy about the diseases, and that, after much discussion, the names, syphilis and gonorrhea, were included in the title of the Association; and this, in spite of the fact that press representatives

who were present stated their publications could give no publicity with those words attached! Which again leads us to think that we are on the eve of a long-desired, successful battle against a disease which the Scandinavian countries, for instance, have been able to subjugate, and which should, therefore, be the more possible for us to vanquish, at least in good part.

* * *

California Medical Association Department of Public Relations Sponsors the California Fight Against Syphilis.—In the Association news columns of this issue,[†] this subject is also discussed. The Department of Public Relations of the California Medical Association is giving active support in the educational work, as evidenced in Chairman Charles A. Dukes' letter printed in this issue.[†] In this fight, the members of the medical profession have very definite obligations; and it should never be said, when the story is told, that physicians in California were found wanting!

VALUE OF BASIC SCIENCE (QUALIFYING CERTIFICATE) LAWS: AS PROVED BY EXPERIENCE

An Important Contribution in Factual Information Concerning Basic Science Laws.—At the 1936 conference of state medical association secretaries and editors, recently held under the auspices of the American Medical Association at its Chicago headquarters, an illuminating address on "Qualification in the Basic Sciences" was given by J. William Holloway, an attorney and member of the American Medical Association Bureau of Legal Medicine and Legislation. Part of its value lay in the fact that the actual experience of the ten states which have enacted basic science laws (Connecticut in 1925; Wisconsin in 1925; Washington in 1927; Nebraska in 1927; Minnesota in 1928; District of Columbia in 1928; Arkansas in 1929; Oregon in 1933; Iowa in 1935; and Arizona in 1933, this law invalid, and 1936), without exception emphasizes not only the value of basic science (qualifying certificate) laws for states having multiple healing-art examining boards, but gives indication that in the not far distant future, in self-protection, all commonwealths with multiple boards will be obliged, in all probability, to enact just such legislation, to prevent the influx of cultist practitioners unable to secure licenses from their respective boards in states having basic science laws.

* * *

The First Basic Science Laws: Studies in California.—Connecticut was the first, and Wisconsin the second state to secure such legislation, to be followed by Washington and Minnesota; and on page 525, in the October, 1927 issue of CALIFORNIA AND WESTERN MEDICINE, comment was made editorially on the new types of statutes which those commonwealths had brought into being in an effort to protect lay citizens from

[†] See page 47, and also Letters, page 61.

healing-art practitioners deficient in that fundamental education so necessary for the proper understanding and interpretation of physiologic and abnormal bodily function. In Los Angeles, a local committee, after study of a possible basic science law, drafted such an act, and, for purposes of education and determination as to legislators' reactions, submitted it to the California Legislature on January 17, 1929, as Assembly Bill 666. At the meeting of the California Medical Association Council held on January 18, 1930, we made a motion for the appointment of a special basic science act committee,* and during the years that have since elapsed this special committee† has made one or more reports annually; both the time and conditions, however, proving unfavorable to the enactment of such legislation.

Two years ago, again, to test out public and other opinion, another draft of a qualifying certificate act, having the number A. B. 1552, was introduced as a legislative measure. In its consideration in the California Assembly, many amendments were attached to it by various interested parties, and no effort was made to bring it out of the assembly committee's hands.

* * *

In California, a Basic Science Act Must Be an Initiative Law.—Renewed study of the problem has brought the conviction that in California a qualifying certificate (basic science) law, that would include osteopathic and chiropractic practitioners as well as physicians and surgeons, must of necessity be an initiative law, because the existing osteopathic and chiropractic acts were enacted through initiative vote of the electorate, and only an initiative law can amend them. If, therefore, the State of California desires a qualifying certificate (basic science) law that will apply alike to each of the existing three California healing art laws, such enactment can be made only by an initiative vote of the citizenry of the State.

* * *

The California Medical Association Referendum in 1935.—The Council in 1935 asked the members of the California Medical Association, in a referendum vote, to express their opinion on the need of a basic science law, the final vote being 2,049 for and only 263 against the proposal to expend the necessary monies to place such an initiative on the 1935 state election ballots. At that time, a total of 186,378 valid signatures was necessary for such placement; but, because of the larger number of citizens who voted in the November, 1936, state and presidential election, a larger number of valid signatures will be required if a qualifying certificate law is to be placed on the state election ballots of the current year.

* See Minutes, item 30, CALIFORNIA AND WESTERN MEDICINE, April, 1930, page 288.

† The Special Committee's officers are listed on advertising page 6 of the current issue.

A list of references to reports and comments on qualifying certificate laws was given in the November, 1935, issue, page 383, and is here noted for the convenience of readers who wish to acquaint themselves with the subject.

Subject Worthy of Earnest Consideration by County Societies and Members.—The attention of component county societies and of their members is again called to this proposed legislation, because no State in the Union is in greater danger from new groups of cultists than California.

It is reassuring to know that the tentative draft of the California qualifying certificate (basic science) act fulfills, in large measure, the requirements which are emphasized by Mr. Holloway in his American Medical Association address.

* * *

Some Excerpts from Mr. Holloway's Address.—Because of Attorney Holloway's intimate knowledge of the various laws, we close these comments with some quotations from his paper, and suggest their perusal by all readers:

The legislatures in the several states had, in the exercise of their police power, enacted laws which are known as medical practice acts, prescribing certain qualifications to be possessed by persons who desired to treat the sick. As medical schools in this country developed to a higher degree of efficiency, and as the need for a greater protection of the public health became more evident, the requirements exacted of would-be practitioners of the healing art became higher and higher. But as the conditions precedent to medical licensure became, in the interest of public protection, more exacting, there arose demands on the part of certain groups of would-be healers for special recognition. These demands were predicated on theories of healing that, it was argued, did not necessitate the same degree of proficiency in medicine as was prescribed by the various medical practice acts. The truth of the matter is, of course, that these groups were incompetent to meet existing requirements, and in order lawfully to practice, it was necessary that they either seek to lower the requirements contained in the medical practice acts so that they could qualify thereunder, or obtain special practice acts for themselves. . . .

‘ ‘ ‘

To examine applicants for certificates of proficiency in the basic sciences, an impartial, nonsectarian board of examiners is created, composed of teachers in the subjects on which applicants are to be examined. . . .

‘ ‘ ‘

The basic science requirement does not apply to practitioners who are legally practicing the healing art in the State at the time of the passage of the act. It applies only to those persons who, subsequent to the passage of the act, seek licenses so to practice. The practice of the healing art is defined in a basic science act in broad, general language. The definition that is advocated is broad enough to include within its scope all modes of practice, by whatever name known. It is necessary, therefore, that those groups not desired to be included in the act be specifically exempted from its requirements, such as dentists, chiropractors, optometrists, etc. . . .

‘ ‘ ‘

Basic science laws, when nondiscriminatory in their provisions and when impartially administered, have met with the approval of the courts on the same ground as have medical practice acts; that is, they constitute a proper exercise by the State of its police power. . . .

‘ ‘ ‘

One yardstick by which the worth of legislation may be measured is the opinions, in retrospect, of its sponsors. . . .

And there is reason enough why basic science laws are regarded so highly in those states that have enacted them. The results of the basic science examinations indicate clearly indeed that poorly equipped persons are experiencing great difficulty in obtaining licenses in such states. A group of better practitioners follows as an inevitable sequence to the enforcement of a basic science requirement. . . .

~ ~ ~

The enactment of a basic science law not only will reduce materially the number of incompetents who annually receive licenses to practice the healing art, but will discourage attempts by other groups to gain a foothold in the State—groups not recognized by law at the time of the enactment of the basic science act. . . .

~ ~ ~

Some of the states have found that convictions are easier to obtain under the basic science Act than under the provisions of the medical practice act. . . .

~ ~ ~

To establish the most effective barrier against incompetent healers, let me repeat, the basic science act should be nondiscriminatory and nonsectarian. It should not be loaded with provisions that will tend unnecessarily to intensify the opposition to enactment and to invite future difficulties without producing any material present benefits. . . .

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 47.

EDITORIAL COMMENT†

TESTS TO DETERMINE THE CURABILITY OF GONORRHEAL URETHRITIS

In this day and age it is astounding to know that many physicians still think the urethra is lined with asbestos, and not with a delicate mucous membrane which is wilfully subjected to more trauma than any other accessible mucous membrane of the body.

It has been a custom for many decades, and still is today, that, to discharge a patient as cured of his gonococcal infection, the urethra should be subjected to the most gruesome tests. As a result of these tests, which will be enumerated, a cured case of gonorrhea is not only prolonged, but subject to complications, namely: stricture, chemical and instrumental urethritis, vesiculitis, prostatitis, epididymitis and cystitis.

We spend two to three months building up a tissue resistance against the invading gonococcus, only to find that one or two injections of silver nitrate, a vigorous massage, or a forced introduction of a sound has prevented us from obtaining

a cure. The injection of a strong silver nitrate solution as a test to determine the permanency of a gonorrheal cure should be condemned. The suffering and torture produced by this chemical is well known to the patient, and the possible complications enumerated above should be borne in mind by the physician. Silver nitrate solution should be used only in the treatment of gonorrhea, and not as a test to determine a gonorrheal cure.

If one wishes to use a sound in the terminal stage of gonorrhea, he should choose the correct caliber and be gentle in its passage. The sound should be guided and not forced into the urethra. Suffice it to say that Keyes' warning, "Oh, so gentle!" in passing a sound, is of paramount importance.

Vigorous massage of the prostate may not only make the patient "jump like a frog" or "see black before his eyes," but may result in an acute prostatitis, vesiculitis, and epididymitis. By applying firm, gentle pressure on the prostate, the secretion obtained can be examined for gonococci.

Since repeal of the Prohibition Act, the beer test is again coming into vogue. The patient may detest beer, but nevertheless he is told by the physician to "guzzle" down several glasses upon retiring and to repeat it for three days. He is then asked to report in the morning for any possible discharge. He may not only become a confirmed beer drinker, but his entire genito-urinary tract and gastro-intestinal tract is subjected to unnecessary abuse. In reality, barring complications, the urethra is the site to be tested for the infection.

In conjunction with the above tests, one may resort to the complement fixation test, and to the examination of a centrifuged specimen of urine, which the patient has voided in the morning.

If we could only realize the number of patients who come to our offices with unnecessary urethral discharges and complications, as a result of these local abusive methods of determining the curability of gonorrhea, the economic, social, and domestic aspects of the situation would be materially benefited.

453 Flood Building.

HERMAN FEINBERG,
San Francisco.

RELATIONSHIP OF TURBINAL ENLARGEMENT TO SEPTAL IRREGULARITIES

During the past ten years it has been the occasional experience of the writer to have patients return after septum resections had been performed, either by him or by others, with the apparently illogical complaint of impaired breathing on the hitherto good side of the nose. To illustrate: If the septum operation had been done to correct a nasal obstruction on the patient's left, after a certain lapse of time, the patient would return stating that although his left side was perfectly clear, his right side, which prior to the operation had been open, was now impaired.

Analysis of the factors involved would seem to indicate these symptoms not to be so unreason-

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

able. Attention has long been directed to the association of enlarged turbinates with the concavity of deviated septums, but sufficient emphasis has not been made upon the correction of this enlargement at the time the resection is done.

With a septum deviated to the left, the breathing space is narrowed on the left and, conversely, is widened on the right. The right inferior turbinate will therefore enlarge, since it seems to be a corollary for the turbinate to enlarge in a compensatory manner and thus narrow down an excessively wide space within the nasal chamber in order to contact a maximum of air that may pass through it.

If the condition has been of short duration, this turbinal enlargement can be classified as an engorgement and, after the septum resection has been performed, will eventually spontaneously shrink down more or less to somewhere within its former size. However, if the enlargement has been long standing, there evolves a tendency toward chronicity and this condition can be classified as hypertrophy or hyperplasia.

Recapitulating the points brought out so far: If the septum is deviated to the left, causing an unusually large breathing space on the right, the right inferior turbinate will enlarge in a compensatory manner to fill the concavity on its side caused by the deviation. However, after the operation this concavity is destroyed, since the septal mucosa now hangs down as a straight partition. Inasmuch as the turbinate is hypertrophied, there is no spontaneous return to former size, and the hitherto good side of the nose is now the one of which the patient complains.

It would appear that differentiation between engorgement and hyperplasia, prior to the septum operation, would clarify the situation and point toward the proper method of procedure. The standard technique is well known—that of applying a weak solution of cocaine to the turbinate under consideration. Shrinkage of the tissue within five minutes would designate the enlargement as a temporary engorgement. However, if the turbinate shows no, or only only a small, change in size within that period of time, we know we are dealing with a true hyperplasia, and attention toward this condition is indicated before the patient is discharged.

516 Sutter Street.

SIDNEY H. GIDOLL,
San Francisco.

HISTAMIN AND EPINEPHRIN TESTS

EPINEPHRIN:

The minute vessels which color the skin contract in the presence of adrenalin, producing an area of pallor. If the venous return from a limb be obstructed by a sphygmomanometer cuff, the pressure in the veins and, therefore, in the venous end of the vessels which color the skin, will build up to the pressure in the cuff. In this way it is possible to measure the contractile power of the minute vessels. In general, this is of the same order as the resting-blood pressure, but is found

to be lower in areas that have recently been exposed to injury, irritants, or burning by heat or light and in those areas such as the face which habitually suffer the minor insults consequent upon the exposure.

HISTAMIN:

Eppinger, and later Lewis, described the triple response of the skin vessels to the intradermal exhibition of histamin. The full development of this response takes from three to eight minutes.

1. *Local Reddening*.—The whole area with which the histamin comes in contact by diffusion presents a reddening due to a relaxation of the minute vessels of the skin. This reaction is commonly masked by 3.

2. *Red Flare*.—This is a widespread (1 to 2 centimeters) area of bright reddening produced by arterial dilatation as the result of an axon reflex excited by the histamin. This flare is unaffected by nerve section until enough days have passed for nerve degeneration to take place.

3. *Wheal*.—A strictly localized wheal is present, associated with a change in the rate at which tissue fluid is exuded from the blood stream.

(4. *Itching*.—As the wheal starts to form, an itching sensation is felt.)

The same factors which lower the contractile power of the coloring vessels in the epinephrin test appear to inhibit the triple response to histamin; but whereas the adrenalin response is dependent solely upon the condition of the minute vessels, the histamin responses—at least the flare and the wheal—are dependent upon the blood supply, the integrity of the local nervous vasodilator system and the relaxing power of the local arterioles.

These reactions have been used to aid the prognosis of diabetic circulatory insufficiencies, in the selection of amputation sites (McNealy and Shapiro) and in the differentiation between occlusive and spastic types of arterial disease (Kramer).

A 3-milligram tablet of histamin is dissolved in one cubic centimeter of water. A drop of this solution is applied to the skin and a single prick is made through this drop just deep enough to avoid drawing blood. After one and one-half minutes the drop of solution is gently removed by absorbing with filter paper. If several pricks are made to insure against the chance of failure, they should be through separate drops at least 3 centimeters distant from each other, in order that variations in the size of the wheal and flare may be appreciated. Some authorities recommend the intradermal injection of histamin as being more certain, but this technique makes it very difficult to examine the wheal.

The epinephrin punctures are similarly performed with 1/1000 adrenalin solution, and the cuff pressure necessary to cause the white reaction to disappear is noted.

University of California Hospital.

ERIC OGDEN,
San Francisco.

ORIGINAL ARTICLES

A DENGUE-LIKE FEVER*

CLINICAL MANIFESTATIONS RECENTLY OBSERVED
IN THE SAN FRANCISCO BAY DISTRICT

By GARNETT CHENEY, M.D.
San Francisco

DISCUSSION by Donald D. Lum, M.D., Alameda; Edward B. Shaw, M.D., San Francisco; Charles W. Lane, M.D., Coronado.

A FORM of fever has recently been observed in the San Francisco Bay district which appears to differ in certain respects from any of the well-recognized disease entities commonly encountered. The manifestations are not unlike dengue fever, and the disorder has been reproduced by the intravenous inoculation of whole blood, which is also characteristic of dengue fever.¹ As it has not been possible to identify the febrile disturbance under discussion with the dengue fever of the tropics, it has been called a dengue-like fever. As the patients suffering from this form of fever are often alarmingly ill, and as certain symptoms and signs are common and apparently characteristic, a wider knowledge of the manifestations may lead to a more exact understanding of the true nature of this condition. With this end in view, an analysis has been made of the findings in twenty cases observed by the author in the summers of 1934 and 1935.

CLINICAL MANIFESTATIONS

As the diagnosis in this group of cases cannot be substantiated as yet by any known specific test, its accuracy may of course be questioned. It has been based on the presence of certain symptoms, the absence of leukocytosis, and an inability to prove that any known disease entity was the cause of the patient's illness. Only those cases have been included which have met these requirements. It was also taken into account that all these cases

* From the Department of Medicine, Stanford University Medical School.

Read before the General Medicine Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

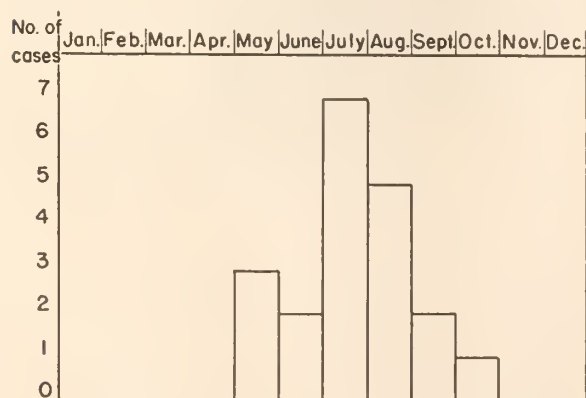


Fig. 1.—Seasonal incidence of twenty cases of the California dengue-like fever.

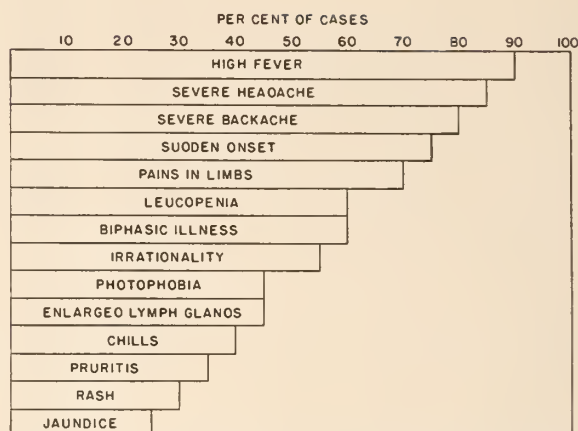


Fig. 2.—The incidence of the common clinical manifestations in twenty cases of the California dengue-like fever.

appeared in the summer months, except for a few in the late spring or early fall. This seasonal incidence is presented graphically¹ in Figure 1, and shows a peak in July and August; but the number of cases is too small to justify any detailed analysis.

The important clinical manifestations are listed¹ in Figure 2 in the order of their frequency. Nearly all of these twenty patients were young adults, but the age incidence varied between seventeen and sixty years. There were eleven males and nine females. A fever of 103 degrees or over was present in eighteen of the patients. In the other two it reached 102 degrees. At times it was well sustained, and in other cases it was very irregular. (Figures 3 and 4.) It was pronounced for six to eight days in every instance, and frequently fell to normal for a number of hours on the third or fourth day. It was occasionally higher during the second half of the illness than the first. Slight daily rises sometimes occurred for as much as a week after clinical recovery. The commonest symptom was a severe headache, which was a major complaint in 85 per cent of the sufferers. It was frequently frontal in location, but sometimes generalized or occipital. It was unusually, but not invariably, most intense early in the illness. It was so severe in four patients that lumbar puncture was performed. The spinal fluids were negative.¹ Figure 2 shows that the next most prominent symptom was severe backache, which was often most intense in the sacro-iliac regions, and seemed far worse than that commonly encountered in the other febrile disorders. It was present in all but three cases.

NATURE OF THE ONSET

One of the striking features of this dengue-like fever was the abrupt onset of the illness. Three-fourths of the patients could state almost to the hour when they became ill, and most of them had felt perfectly well previously. Another impressive characteristic was the presence of pains in the limbs which was noted in 70 per cent of the cases. These pains were so acute in some individuals that they would lie perfectly quiet, afraid to move. In some the joints were also stiff and pain-

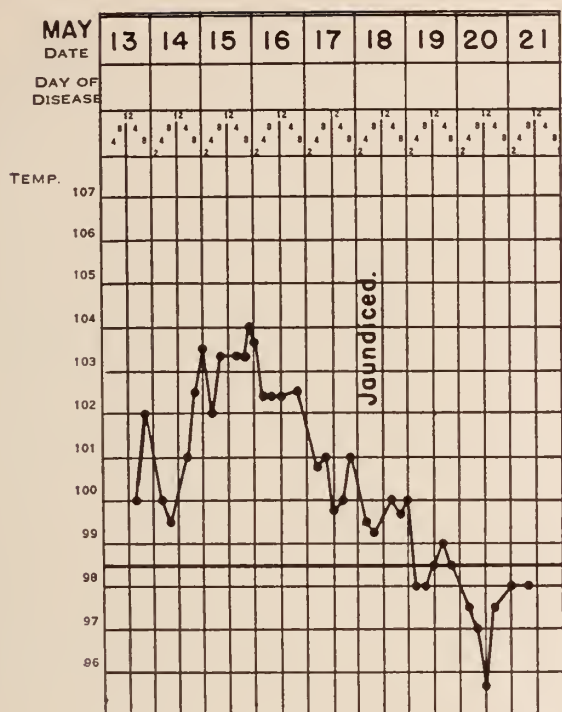


Fig. 3

Fig. 3.—Temperature chart of a case of dengue-like fever, showing characteristic, high, well-sustained fever of seven days' duration. The patient became jaundiced on the sixth day of illness.

Fig. 4.—Temperature chart of a case of dengue-like fever, showing rapid rise and fall of temperature accompanied by chills. The patient had profuse diaphoresis.

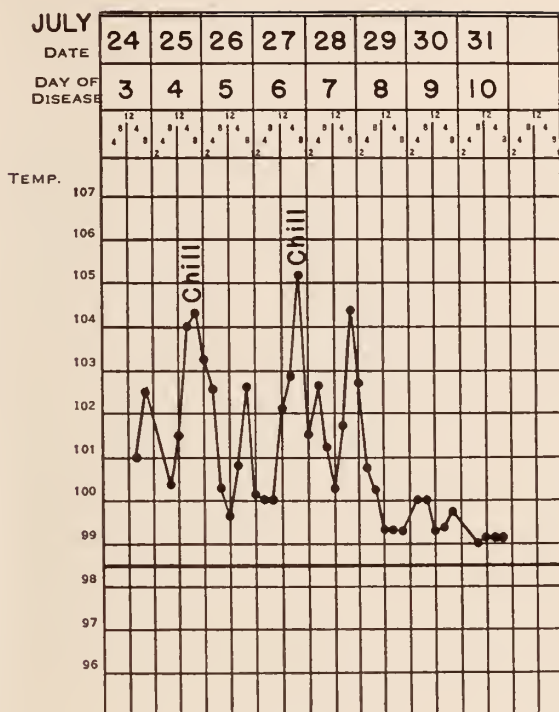


Fig. 4

ful. Three patients were at first thought to be suffering from trichinosis. The term "break-bone" fever seemed justly applicable. An outstanding finding in this group of cases was the white blood cell count. In only one instance were there over 10,000 leukocytes present, and then there were 12,000. It should be emphasized that this absence of leukocytosis was exhibited in the presence of high fever. Even more unusual was the presence of leukopenia (white blood cell count less than 6,000) in 60 per cent of the cases. The lower white cell counts tended to occur in the latter part of the illness. The lowest count was 2,800.¹ Follow-up leukocyte counts were not carried out.

INTERESTING SYMPTOMS

Slightly over half the patients presented a definitely biphasic illness. Not only was the fever abated on the third or fourth day, but all prostration and aching would disappear and the patient would feel that he had recovered. This false sense of well-being would last but a few hours to a day, before symptoms would return which might differ in nature or be more violent than in the first episode of the disease. Such a secondary exacerbation may be considered quite characteristic. Half the patients were irrational at some time during their illness, and the mental disturbance tended to occur in those with the highest fever. In five instances the delirium, together with other symptoms, strongly suggested typhoid fever. Blood cultures and Widal's were negative in each. Forty-five per cent of the patients complained of photophobia, which usually lasted two

or three days. In the majority of these conjunctivitis, palpebral edema and soreness of the eyeballs accompanied the sensitiveness of the eyes to light.

At some time during the course of the illness, nine patients presented an enlargement of the lymph glands which was usually generalized. Cervical and postauricular adenopathy were often the first noted. The glands were not over 2 centimeters in diameter, discrete and not tender, and tended to subside during the convalescence. A major complaint in 40 per cent of the cases was a violent chill. In some this was a single occurrence at the onset of the fever or during the second effervescence. However, three patients ran what may be aptly termed a septic course of fever, with repeated chills occurring two or three times a day and followed by drenching prostrating sweats. Another characteristic and very troublesome symptom was the itching which tormented a third of those ill. It appeared late in the course of the disease and persisted into convalescence, and was unassociated with rash or jaundice. Many of these sufferers scratched themselves badly. A definite erythematous, macular or urticarial rash was present in six patients, appearing either at onset or on the fourth or fifth day of illness. In no instance were the skin lesions germane to drug therapy. The last common manifestation of this dengue-like fever listed in Figure 2 is jaundice. It appeared during the last part of the illness in one-fourth of the cases and was never intense. The icteric index ranged from fifteen units to thirty units. The icterus persisted about two

weeks. The liver was palpable and tender in two of the five jaundiced patients.

OTHER FINDINGS

Certain other findings of interest were encountered in a few patients. A loss or perversion of the sense of taste, anorexia, nausea, vomiting, constipation, and abdominal pains were relatively rare gastro-intestinal complications. The tongue often showed a thick, creamy coating. Evidence of upper respiratory-tract infection was conspicuous by its absence. Three patients developed cough, and some râles at the lung bases late in their illness; actually at a time when nearly all other symptoms had disappeared. Two of the eleven males complained of severe pains in the testicles without objective findings except moderate tenderness. Three patients had palpable spleens during the period of high fever. The pulse rate was usually increased in proportion to the temperature, but persistent bradycardia occasionally occurred. Two cases had transient albuminuria. None developed anemia. The sedimentation rates were moderately increased in the six patients upon whose blood they were performed.

DIAGNOSIS

Trying to paint a picture of a disease on paper is inadequate compared with the clinical examination and study of patients under a physician's care; however, this description strongly suggests that a disease entity new to the San Francisco Bay region has made its appearance. At present the diagnosis must be based on a fever of fairly high degree, and of about a week's duration, accompanied by prostration, severe aching and certain other symptoms as enumerated, and the white blood cell count must be normal or low. Evidence of respiratory tract infection is characteristically lacking, and the disorder typically appears in the summer months. The complete differential diagnosis has been dealt with in a previous communication,¹ but it should be stated here that the chief difficulty may arise in separating this dengue-like fever from influenza. The appearance of the infection in the middle of the summer, the lack of family incidence, as all the cases reported are isolated ones, the complete lack of upper respiratory tract symptoms, and the presence of certain findings usually foreign to influenza such as the rash, itching, glandular adenopathy and jaundice, would make the diagnosis of influenza untenable in these cases.²

ETIOLOGY

The etiology of this fever is at present unknown, but it seems likely that it belongs to the group of filterable virus infections. There is no known vector, although some of the patients had been bitten by mosquitoes, and a number by fleas within ten days of the onset of the illness. A positive identification with dengue fever would of course clear up these points. The treatment of this fever is symptomatic; and the prognosis is excellent, although some patients suffered from asthenia and pains in the limbs for as long as two weeks after the acute illness.

210 Post Street.

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DISCUSSION

DONALD D. LUM, M. D. (1361 Park Avenue, Alameda). Doctor Cheney has used a great deal of acumen in segregating this group of cases.

The clinical manifestations clearly fit into the group of dengue-like fevers. There are only two missing links in the absolute proof of the diagnosis. One is the finding of the vector, and the second, the definite proof that one attack will confer an immunity. I hope that Doctor Cheney will be able to inject one of these patients with blood from a future case. This would prove the presence of an immunity to this type of fever. It would be interesting, in a recovered case of proved dengue fever, to inject the blood as well to demonstrate the immunity of dengue to this entity.

Although a definite vector has not been found, there are closely related mosquitos in this vicinity which may have some bearing on the problem.

So often these patients are placed in the general diagnostic basket of influenza. With the spontaneous recovery of the patient, they are considered as such, without further thought. Influenza can be definitely ruled out in this group by the presence or absence of the symptom-complex, as discussed by Doctor Cheney.

With our rapidly increasing migratory population, we are very apt to have an invasion of tropical and sub-tropical diseases. The itinerants may bring in not only the etiologic factor, but the vector as well. It behooves us all to consider these factors in our differential diagnosis.

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EDWARD B. SHAW, M. D. (384 Post Street, San Francisco).—Most of us are prone to accept undiagnosed febrile illnesses of short duration as influenza, the definition of typhoid as "intestinal influenza of three weeks' duration" is almost pathetically true. The correction of similar mistakes is illustrated in the history of medicine; measles was finally differentiated from smallpox, typhoid was gradually distinguished from typhus, and more recently relapsing fever was identified among just such a group of cases as this paper describes. There is, of course, the contrary possibility that a number of different infections may be erroneously classified into a single syndrome.

In a majority of these patients, at least, there seems to have been a fair degree of correlation of symptomatology and clinical findings, and convincing evidence of the absence of any of the commonly recognized disease entities. The disease seems not demonstrably to have spread by contact, and yet could be transferred by inoculation of blood. The possibility naturally presented that the disease is spread by an insect vector is an intriguing one, but the paucity of biting insects which frequent San Francisco fails to support this idea. We have few mosquitos and certainly do not have recognized vectors of dengue fever. Portola was probably the first to comment on the size and voracity of the San Francisco flea, but the infection just described has hardly been sufficiently widespread to suggest that the flea is the responsible vector.

Certain points of similarity exist between this disease and exanthum subitum, a common disease of infancy. I would not propose that the two diseases are identical, but both are characterized by low communicability, high fever of short duration, splenomegaly, adenopathy, and a rash. In both the etiologic agent is unknown, and the diagnosis depends entirely on clinical differentiation.

If one might paraphrase a well-known, but nonmedical, authority, there must be many things not comprehended in the philosophy of modern medicine. Progress in medicine proceeds not only from the laboratory. The frontiers of medical knowledge lie at every bedside, and accurate observation, intelligent correlation, and the insistent search for truth will inevitably lead to new clinical discoveries of no less value than those which come by way of the more exact sciences.

CHARLES W. LANE, M.D. (102 Bank of Coronado Building, Coronado).—I have been interested in Doctor Cheney's paper for two reasons: First, because he is dissatisfied with our usual method of classifying all influenza-like fevers simply as influenza without making any real effort to establish positive diagnoses and, in the second place, because the peculiarities of dengue fever and its possible occurrence in regions hitherto unaffected are points that should be given general recognition.

If the cases described by Doctor Cheney were dengue fever, I am sure there would have been a real epidemic with probably many thousands reported, as is customary when this illness attacks a non-immune area. Dengue cases appear in the same house or in near-by houses, and rapidly spread in all directions through the community. The appearance of widely isolated cases would be difficult to explain, as the carrier is a house dweller and does not usually travel great distances.

It has been shown that a temperature of 64.4 degrees Fahrenheit destroys the virus in the mosquito. The summer months in San Francisco are generally quite cool, and it is not uncommon for the temperature to remain below this point for a considerable time.

Except in rare cases, dengue is not ushered in with a real chill, but with chilly, "grippy" sensations. The leukopenia in dengue is not only relative but definite, the average patient dipping down to five thousand or less. A rash in dengue is found in a larger percentage of cases, and it might be of interest to note that frequently cases of dengue are said to have no rash when a careful examination will reveal one along the extensor surface of the great toe. Itching is infrequent, and jaundice occurs in a very small percentage of cases.

The sudden onset, violent aching, short duration of fever and the tendency to a temperature curve of the camel-back type, together with a rash, would naturally cause Doctor Cheney to think of dengue, but it seems obvious to me that he was dealing with some other disease.

One interesting fact that I have never seen mentioned in any article on dengue fever is that so many who have had it will notice for a year or more following, that at intervals of from four to six weeks there is an afternoon and evening recurrence of general aching. It would be interesting to know for how long a period the blood remains infective.

It is, of course, possible that the airplane will introduce dengue to any community harboring the proper mosquito at a time of year when the temperature is above 64.4 degrees Fahrenheit.

BASAL METABOLISM*

DETERMINATION OF THE ZERO POINT IN A NORMAL GROUP IN SOUTHERN CALIFORNIA

By JOHN MARTIN ASKEY, M.D.
Los Angeles

DISCUSSION by Clarence G. Toland, M.D., Los Angeles; H. Clare Shephardson, M.D., San Francisco.

THE value of the basal metabolism test depends upon the degree of variation from the normal and upon the proper clinical interpretation of this variation.

In Southern California we are concerned with the variation of the determined basal metabolism from that of normal persons in Southern California.

Up to the present the basal metabolic rate has been compared with the standards for normal as determined in Washington, New York, and Boston.

We wish to give the results of a study of 108 normal persons in Southern California to ascer-

tain the range of the basal metabolic rates in a normal group in this climate and in this particular population.

CHOICE OF A STANDARD

What standard shall be used in computing whether or not a certain oxygen consumption is above or below the normal consumption? The choice of an improper standard can make a marked difference in the basal metabolic figure. If a normal person has a basal metabolism of zero according to the Mayo standards, it would be plus nine according to the Krogh standards. A basal metabolic rate of zero by the Harris-Benedict formula is minus 6 when calculated by the Aub-Du Bois standard. It is surprising that figures are reported in the literature almost invariably with no statement as to the standard used. A correction factor is always necessary in order to compare figures obtained by different standards. Tables 1 and 2 show the correction factors as determined by Jenkins.

These differences exist not only because some are based on surface area figures and others on weight, but also because there are actual differences in the levels of normal groups in different localities. Even if a single standard is employed, normal groups in different sections of the country will show varying levels.

Before any figures for oxygen consumption can be compared with any standard without the likelihood that there will be an error of from 1 to 9 per cent, it must be determined which of the various standards is the best when applied to normal persons.

A determination of the mean metabolism, or the zero point of a normal group, would tell whether it corresponded to the higher normal prediction values as represented by the Aub-Du Bois tables or the lower values as represented by the Dreyer standard. Use of the corrected standard would result in the elimination of several points of error.

Any conclusion drawn as to the degree of variation from normal of a basal metabolism is not correct unless the zero point from which the variation is measured is known to be correct.

NORMAL RANGE OF BASAL METABOLISM

The mean metabolism of the 108 normal persons was determined according to the standards of both Aub-Du Bois and Dreyer. These were chosen for several reasons. The standards of Aub-Du Bois are in more general use than any other, and are based on the surface-area theory. The Dreyer standards have been shown to be very accurate, and represent the standards calculating normal metabolism in proportion to the weight rather than surface area.

The dispersion of the basal metabolisms around the two zero points, as determined for the two standards, gives the normal range according to the two standards.

TYPE OF NORMALS

There were sixty-four women and forty-four men, ranging in age from sixteen to sixty. Most

* Read before the General Medicine Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

TABLE 1.—*Correction Factors for Comparison of Standards for Men (Jenkins)*

Rate Compared	Rate Compared With					
	Krogh Per Cent	Dreyer (Observed) Weight Per Cent	Harris- Benedict Per Cent	Aub- Du Bois Per Cent	Bailey Per Cent	Mayo Per Cent
Krogh	0	-2	-2	-7	-7	-9
Dreyer (observed weight) ...	+2	0	0	-5	-5	-7
Harris-Benedict	+2	0	0	-5	-5	-7
Aub-Du Bois	+7	+5	+5	0	0	-2
Bailey	+7	+5	+5	0	0	-2
Mayo	+9	+7	+7	+2	+2	0

of the men were business and professional men; the women were housewives, business women, and students. They represented an average cross section of the type seen in private practice. A portable Benedict apparatus, modified by the Sanborn motor blower, was used. The tests were done in Dr. C. G. Toland's office by two technicians who have been doing this work for over ten years. The average of two tests was taken, rather than the lower.

The basal metabolism of the normals must be studied under the same conditions used for clinical determinations. If one-day tests are to be compared with a standard, it necessarily should be a standard derived from one-day tests. Inasmuch as most clinical basal metabolism determinations are not done several days in succession, they must be considered as one-day tests and compared with a standard based on such tests. The Aub-Du Bois and Mayo standards are based on a high proportion of first-day tests.

ERRORS IN BASAL METABOLISM DETERMINATION

The errors that arise in basal metabolism determinations, in addition to those due to a faulty standard, are chiefly those of faulty technique and a varying basal emotional state of the patients. Technical errors account for 2 to 3 per cent error even in the best hands. Due to the long experience of our technicians, we feel that technical error was minimal. The varying basal state of even normal individuals is at times marked, and this usually accounts for the wide degree of normal dispersion.

The majority of our normals were adults who cooperated well when the test was explained.

We present this group as a representative normal group of the type seen in private practice, but not a cross section of the whole population.

THE ZERO POINT

In the group of 108 normal persons, the zero point according to the Aub-Du Bois standard was at minus 6.8. According to the Dreyer formula (Stoner's tables) the level was minus 3.4.

By the Aub-Du Boise standards, the great bulk of the normals was on the minus side of the un-

TABLE 3.—*Comparison of Aub-Du Bois (Sage) and Dreyer Standards in Predicting Basal Metabolism of 108 Normal Persons in Southern California*

	Per Cent in ±10 Range	Per Cent in ±15 Range
Sage Standards:		
(With uncorrected zero point)	60.3	84.2
(With corrected zero point) (-6.8)	74	90.8
Dreyer Standards:		
(With uncorrected zero point)	84.2	87.9
(With corrected zero point) (-3.4)	86.2	94.4

corrected zero point. Of the 108 normal persons, eighty-eight had figures below the calculated calories for normal.

The Dreyer standards gave results closer to the zero point, but even so, seventy-six of the one hundred and eight had subnormal figures.

The mean metabolism of the Aub-Du Bois standards was, consequently, lower, minus 6.8 as compared with minus 3.4, according to the Dreyer

TABLE 2.—*Correction Factors for Comparison of Standards for Women (Jenkins)*

Rate Compared	Rate Compared With					
	Krogh Per Cent	Dreyer (Observed) Weight Per Cent	Harris- Benedict Per Cent	Mayo Per Cent	Aub- Du Bois Per Cent	Bailey Per Cent
Krogh	0	-1	-2	-5	-6	-6
Dreyer (observed weight) ...	+1	0	-1	-4	-5	-5
Harris-Benedict	+2	+1	0	-3	-4	-4
Mayo	+5	+4	+3	0	-1	-1
Aub-Du Bois	+6	+5	-4	+1	0	0
Bailey	+6	+5	+4	+1	0	0

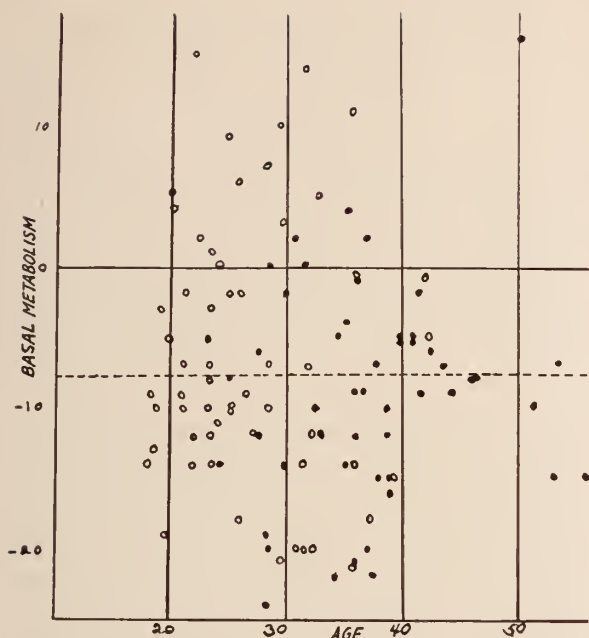


Chart 1.—Dispersion of basal metabolism of 108 normal persons in Southern California (Aub-Du Bois standards).
●—Male
○—Female

standards. These figures are then the true zero points of these standards when applied to our normals.

A basal metabolic rate of plus 10, calculated according to the Aub-Du Bois standards, is actually 16.8 points above the corrected zero point. A figure of minus 16.8 is only ten points below the correct zero point.

DISPERSION OF THE RATES

Only 60 per cent of the normals fell within a plus 10 minus 10 range of the zero point, according to the uncorrected Aub-Du Bois standard. When the dispersion was determined with minus 6.8 as the zero point, 74 per cent fell within the plus 10 minus 10 range.

The Dreyer standards were found to be more accurate than the Aub-Du Bois standards in several ways. Not only did the zero point of our normals agree more closely with that of the Dreyer standard, but there was a more compact grouping of the normals.

Even according to the corrected Aub-Du Bois zero point, 26 per cent were outside a plus 10 minus 10 range. Only 13.8 per cent were outside this latitude, according to the Dreyer standard.

There was much more chance of the basal metabolism of our normal group falling in a plus 10 minus 10 range if calculated by the Dreyer standards than if calculated by the Aub-Du Bois standards. Similarly, more were within the plus 15 minus 15 range when calculated by the Dreyer formula.

Apparently the weight formula was much more accurate in predicting the normal metabolism in our group than the surface area formula.

Using the corrected Dreyer standards, one is reasonably sure that 95 per cent will be within fifteen points of the zero point.

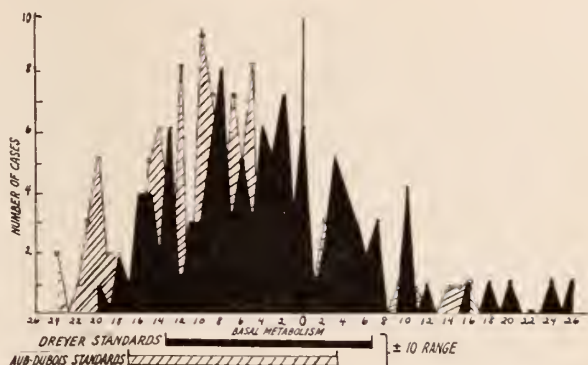


Chart 2.—Distribution of basal metabolism of 108 normal persons in Southern California. Calculations made according to Aub-Du Bois and Dreyer standards.

Jenkins has shown that the relative prediction accuracy of the Harris-Benedict and the Dreyer standards are similar, so they may be considered of equal value here. The Dreyer standard has the added advantage of greater simplicity of application. A single table, as devised by Stoner, can be used instead of different tables for adults and children as needed for the Harris-Benedict tables.

We are using this standard now, and with the corrected zero point feel that we have limited materially the error due to a faulty standard and have avoided resultant clinical misinterpretation.

Regardless of the basal metabolism reading obtained, we must accept it only as a laboratory aid and always of secondary value to the clinical diagnosis. If we are to use it, it should be sharpened in every possible way as a diagnostic instrument. Even then, because of the normal dispersion, it is advisable to allow 15 points variation from the zero, instead of delimiting the normal range to 10 points. Diagnosis made because of slight variations from normal should always be regarded as questionable, but especially so unless the basal metabolism is compared with a standard, the zero point of which has been established by testing normals in that particular region.

SUMMARY AND CONCLUSIONS*

1. Every laboratory should individually determine its zero point according to the standard it uses.
2. In a group of normal persons in Southern California the zero point, based on one-day tests, was minus 6.8 according to the Sage standards of Aub-Du Bois, minus 3.4 according to the Dreyer formula.
3. The Dreyer standards apply more accurately to the normal group studied than the Aub-Du Bois standards.
4. Basal metabolism figures should always specify the standards used.
5. Deviation of 15 points on either side of the established zero point should be considered within normal range.

1930 Wilshire Boulevard.

* We wish to acknowledge our indebtedness to Dr. C. G. Toland for his interest and assistance in helping with this paper.

DISCUSSION

CLARENCE G. TOLAND, M.D. (1930 Wilshire Boulevard, Los Angeles).—For a number of years we have been interested in Doctor Askey's work.

We used to be puzzled by a lack of agreement between basal metabolic rates and clinical impressions, and some of the error in interpreting the basal metabolism was due to use of a standard established in a colder climate.

In a subtropical climate, as in Southern California, the basal metabolism is reduced normally; and unless this is recognized, faulty conclusions will be drawn. The discovery that the Aub-Dubois standard for normals predicted values nearly seven points off, when applied to normals here, led us to discard it. We have found the Dreyer standard is much better in predicting basal metabolism in Southern California, and we feel that others checking normal metabolisms here will also find it so. Standards must be chosen according to geographical location, and the only way to know is to find out by determination on normals.

Doctor Askey has done this in Southern California, and I think we can all profit from it. I want to emphasize, too, the need for always stating the standard used when reporting a basal metabolism. Only in this way can we compare rates which have been calculated by different standards.

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H. CLARE SHEPARDSON, M.D. (384 Post Street, San Francisco).—The importance of the data concerning determination of the so-called "zero" point in standards for basal metabolism tests submitted by Doctor Askey varies somewhat, depending on the use to which the test is to be put. As is well known, the minimal amount of energy or number of calories sufficient to support the basic metabolism of a resting individual in the postabsorptive state is known as the basal metabolism. The human machine requires energy for its operation; even during rest, either awake or asleep, vital processes continue.

These require fuel; consequently, the first principle of adequate nutrition is to provide the minimum energy required to support this basic resting metabolism.

Clinically, the basal metabolism of an individual is ascertained either for the purpose of supplying an adequate dietary regimen, or for diagnostic purposes—usually to determine the degree of activity of the thyroid gland; although it should be pointed out, parenthetically, that alterations in the activity of other ductless glands may profoundly influence the metabolism.

Doctor Askey's thesis is concerned only with the second of these purposes. As he has concisely pointed out, there are several sources of error inherent in the method of determining the fundamental metabolism, chief among which (excluding technical errors which for the most part are eliminated as the experience of the technician increases) is the varying emotional state of the patient. As a rule, therefore, small variations should be disregarded, unless—and this is important—they occur on the "minus side." It is almost axiomatic that every factor which adversely influences the test tends also to raise the result. In other words, the lower the rate the nearer it approaches actuality. It, therefore, seems obvious that the clinician should only be interested in variations whose increment is greater than at least 10 or 15 per cent, provided the result is above the normal standard.

On the other hand, much smaller changes found in patients with a lowered basal rate may be quite significant. And it is known that the normal standards vary not only with the sex of the individual, but with his or her race, occupation, and the climate in which the person lives. If these factors tend to lower the "zero" point—and they frequently do—5 or 10 per cent in the general normal population of a given locality, the mistakes that may arise in the interpretation of results become obvious.

As Doctor Askey points out, a basal metabolism test should be accepted only as a laboratory aid, and always as of secondary value to clinical impressions; yet if we are to use the test at all, it should be performed as accurately as possible and the results interpreted as correctly as conditions permit.

Commendation is due Doctor Askey for calling attention to a possible source of significant error in determining the basal metabolic rate, a factor which, with little effort, can be entirely eliminated.

MOBILE RIGHT COLON: CLINICAL CONSEQUENCES*

By LEROY BROOKS, M.D.
San Francisco

DISCUSSION by Loren R. Chandler, M.D., San Francisco; John M. Schmoele, M.D., Los Angeles; William L. Bender, M.D., San Francisco.

THIS report is not concerned with the subject of general visceroptosis, but rather with abnormalities of the position and motility of the ascending colon and the clinical consequences.

ANATOMIC BASIS

In the development and rotation of the gastrointestinal tract, the cecum and ascending colon are the last to take their final position. Normally, the ascending colon fuses with the posterior abdominal wall and is broadly attached in the right lumbar region. This rotation and fusion process may vary, from failure of rotation, to abnormal mobility of varying degrees. The right colon may possess a true mesentery or the lower half of the ascending colon may be normally fixed and the upper half abnormally mobile—a condition which causes kinking of the bowel—or the upper part with the hepatic flexure may be normally fixed and the lower part mobile, which may lead to axial rotation of from 90 to 120 degrees, with partial obstruction. Along with the lack of normal fixation, abnormal, congenital or developmental bands are prevalent. Although studies on cadavers show that between 20 and 25 per cent of people have some abnormality of fusion of the right colon, we know that only a relatively small number of these develop symptoms. An explanation of this would probably involve the degree of abnormality, the inherited strength or weakness of the tissue fiber, the relative ability of people to stand pain or discomfort, abnormal relation of adjacent organs from lack of uniform ptosis, stress and strain, occupation, proper or improper nourishment, stability or instability of the autonomic nervous system, the upright position and intestinal stasis.

HOW SYMPTOMS ARE PRODUCED

The writer agrees with Carslaw and Grey that symptoms, when present, are produced by stasis in the right colon, with traction on the narrowly attached mesentery and/or abnormal bands, upsetting the normal physiology of the autonomic nervous system with spasm of the pylorus, ileocecal and other sphincters of Keith, and mechanical and functional obstruction with distention of the involved viscera. An abnormal amount of toxic absorption, as a result of stasis, no doubt also plays a part in the production of general symptoms in some cases.

ONSET OF SYMPTOMS

The onset of symptoms depends upon the onset of stasis which most commonly occurs about the age of puberty. Symptoms may occur in children or in older people, and are more common in

* Read before the General Surgery Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

females than in males, not infrequently beginning after one or more pregnancies. In children the picture is that of the undernourished, poorly developed, dyspeptic, constipated, colicky child of the linear type which is so well known to all. Constipation is a constant symptom.

At first there is discomfort, usually dyspepsia and loss of weight. Later pain occurs and varies in location, which depends upon the degree of abnormal mobility of the right colon and points of attachment of abnormal bands and the viscera mechanically or functionally involved. While the location of the pain or discomfort varies in different patients, the type and location of the pain is remarkably constant in a given patient, but the time and duration of the pain are most erratic. It may be present for one or several days, then mysteriously disappear for a day or more, only to recur exactly in the same place and to be always of the same type. In fact, a most characteristic feature of the history is this erratic "constant inconstancy" of the symptoms. The symptoms are usually worse toward the end of the day, or following strenuous work or exercise. The patient will often be relieved by cathartics and enemas, or upon assuming the reclining position. There may be, and in the worst cases often is, a history of repeated attacks of diarrhea accompanied by an increased amount of pain, beginning in the region of the cecum, but with absence of the usual amount of mucus common in mucous colitis. Stool examination does not reveal any specific cause of the attacks which are due, we believe, to excessive putrefaction and fermentation with typhlitis and diarrhea.

LATER SYMPTOMS AND SIGNS

As time goes on, more weight is lost; the patient becomes nervous, and is often classified as a neurasthenic and drifts from one doctor to another. It is, in general, characteristic of these patients that, after the history and examination have been completed, their conditions do not fit into any of the better-known pathologic entities within the abdomen. Neither do they respond to medical or dietary treatment, as do ulcers, gall-bladder disease, colitis, etc. Not infrequently they lose their appendix, gall-bladder, or ovary, as the result of an honest attempt to give relief. Finally they develop colitis, gall-bladder disease, duodenitis, ulcers, etc., and the picture becomes complicated and the original symptoms are overshadowed by the more constant recognizable ones of the organic changes. While there is only a small percentage of people with abnormal mobility of the right colon who have symptoms, no doubt there are many who go unrecognized or upon whom an erroneous diagnosis of chronic appendicitis, neurasthenia, etc., is made.

The gastric symptoms predominate when the hepatic flexure is not fixed, and the pyloric end of the stomach and duodenum are dragged downward and the load of the heavy right colon is partially borne by the tissues toward the cardiac end of the stomach. This type may have pain in both the right and the left upper quadrant, indigestion, loss of weight, abundance of gaseous

eructations—sometimes to the point of social embarrassment—and nervousness is a common feature.

When abnormal congenital bands are attached to the colon and gall-bladder, one is apt to elicit symptoms referable to this region. Traction through the superior mesentery and right colon arteries may lead to chronic obstruction of the duodenum, attacks of vomiting, headaches, and acute upper abdominal pain (acute duodenitis) lasting from three to five days, often requiring rest in bed and sometimes morphin for relief. There is no muscle-guarding as in gall-bladder disease. In between attacks, the symptoms are those of chronic duodenal ilius. The symptoms differ from ulcers of the stomach or duodenum or gall-bladder disease in the erratic nature and lack of relief by diet and medical regimen. Patients may or may not be relieved by taking food, and usually have given up dieting, as they feel as well when eating one thing as another.

Occasionally, pain in the right lumbar region is a prominent feature. This may vary from discomfort to Dietl's crisis, with the well-known symptoms, and is due to a reno-colic band connecting the ptosed ascending colon with the anterior surface of the kidney, dragging the latter downward. Fixation of such kidneys offers only temporary relief, since the heavy right colon will again drag the kidney downward.

RIGHT LOWER QUADRANT TYPE

The right lower quadrant type is the most common and is met in patients who have more or less normal fusion of the hepatic flexure of the colon, but with lack of fusion of the cecum and a varying amount of the ascending colon. They have right lower quadrant pain, constipation—usually indigestion milder than in the incidences with greater lack of fusion, as cited above. The right lower quadrant pain is dragging or aching in type from overdistention of the cecum, or traction of congenital bands, is not present every day, worse on exercise, and when the constipation is worse, relieved by cathartics, enemata, and rest in bed. In some cases there is superimposed upon this dull right lower quadrant pain, a colicky type of pain which is usually due to a large-mouthed appendix trying to empty itself, or one that contains fecoliths. It is not uncommon for this type to have an acute attack simulating in some respects an attack of acute appendicitis, but differing from acute appendicitis in that the pain usually begins and stays in the right lower quadrant of the abdomen. There may be—but usually there is not—nausea or vomiting. There is lack of elevation of the temperature, lack of an increase in the leukocyte count as seen in acute appendicitis, and there is generally no actual rigidity, but extreme tenderness upon pressure in the right lower quadrant of the abdomen. Operation upon such patients during such an attack, which is often the procedure of wisdom, will reveal a heavy, thickened, grayish, edematous cecum, filled with liquid and gas and with enlarged lymph glands in its mesentery, and an insignificant appendix, the removal

TABLE 1.—*Types*

Cecal	51	(3 duodenojejunostomy) (General plastic)
Gastric	1	
Duodenum or renal	16	
General ptosis	1	
Total	69	

of which will not prevent the patients continuing to have their dull right lower quadrant pain, nor their occasional attack, similar to the one for which they were operated upon.

Physical examination of these patients does not furnish diagnostic aid comparable to that furnished by the history, except to help rule out other better known lesions. The types who have lack of fixation of the hepatic flexure are of the linear type, with narrow, flat, long chest, a small upper and large lower abdomen, with a straight lumbar spine. Those interested in this body type in connection with abnormal mobility of the right colon, are referred to publications by Longyear, Coffey, Goathwaite, and others. Contrary to general opinion, the right lower quadrant type may be met in patients of normal build or of the lateral type.

BILIARY TYPE

In the biliary type, discomfort is usually elicited by pressure over the dilated duodenum. During the examination the duodenum can often be emptied of its liquid and gas contents by pressure of the hand over this viscus, with the patient in the knee-chest position, and the patient has often learned that this position gives relief.

RENAL TYPE

In the renal type the movable kidney can be palpated. The right lower quadrant type complains when pressure is made over that quadrant, and gaseous distention of the cecum is excessive and one can sometimes hear the contents splash or gurgle. The cecum can often be outlined by percussion.

DIAGNOSIS

The x-ray is a valuable aid in determining the abnormal mobility of the right colon, dilatation of the duodenum, spasm of the pylorus and stasis in the cecum, and in helping to rule out other pathology.

The differential diagnosis is made by a process of elimination of the other clinical entities with simulating symptoms. A detailed accurate history properly interpreted is compulsory before arriving at a tentative diagnosis.

Since many of these people are nervous it becomes necessary to determine whether the nervous

TABLE 3.—*Results*

Relieved of symptoms	63	91.3%
Improved	4	5.8%
Failure	2	2.9%

symptoms are primary or secondary to the loss of weight and run-down condition. This is often difficult and at times impossible. But if the patient had indigestion, loss of weight, pain in the abdomen, constipation, etc., before the onset of insomnia and other nervous symptoms, and particularly if she is annoyed or aggravated by her ill health instead of telling her story with apparent pleasure, the chances are her abdominal trouble is primarily organic due to traction on the mesentery of heavy proximal colon, with upset of the autonomic balance and mental outlook.

It should ever be kept in mind that since an abnormally mobile right colon is so often present without producing any symptoms, it should be incriminated only after all the other better-known pathologic entities have been ruled out by the history, examination, and a thorough exploration of the abdomen at the time of the operation.

PROBABLE EXPLANATION OF SYMPTOMS

The following facts are significant in connection with the hypothesis that the symptoms are caused by traction on the mesentery or developmental bands attached to the parietal peritoneum or adjacent organs, and mechanical stimulation of the sympathetic nerves:

The gastro-intestinal tract has a dual nerve supply with delicately balanced, opposing functions. On the one hand is the sympathetic proper, which comes from the thoracic and upper lumbar cord, and on the other the parasympathetic which is supplied through the vagus and the sacral autonomies. Stimulation of the sympathetic results in a relaxation of the muscles of the gastro-intestinal tract and tends to inhibit peristalsis, but tightens the sphincters. The sphincter at the cardia, the pyloric sphincter, the ileocecal sphincter and probably the other sphincters of Keith's, are caused to contract by stimulation of the sympathetic nerves.

Stimulation of the parasympathetic causes diametrically the opposite effect from that of stimulation of the sympathetic. It is, however, well known among research workers and clinical surgeons that tension on the mesentery or the parietal peritoneum results in a response on the part of the sympathetic nervous system, and not in a response on the part of the parasympathetic.

TABLE 2.—*Sex and Age Incidence*

	Under 10 Yrs.	10-19 Yrs.	20-29 Yrs.	30-39 Yrs.	40-49 Yrs.	Total
Female	2	21	20	8	2	53
Male	3	4	6	3	..	16
Total	5	25	26	11	2	69
Percentage	7.3%	36.2%	37.7%	15.9%	2.9%	100%

During operations under local anesthesia (not spinal) it can often easily be observed that the peristalsis of the intestines is very active. Slight tension on the mesentery or the parietal peritoneum will cause these intestinal movements to instantly cease and the bowel will, within a few seconds, be seen to dilate to twice or three times its original size. This is evidence of a sympathetic response or reflex to the tension on the mesentery, and the amount of tension necessary to demonstrate the above can easily be furnished by the weight of the ptosed, heavy, thickened, liquid-filled, swinging right colon. At operation on one of these patients, one is struck by the weight of the cecum and the first part of the ascending colon when it is lifted out of the abdominal cavity. This traction would not only cause spasm of the pylorus, hyperchlorhydria, and indigestion, but would interfere with peristalsis and favor stasis and, when long-continued, would establish a vicious circle and have a profound effect upon the individual's nervous system and general well-being.

It will be remembered that practically all our water is absorbed from the right half of the colon, and also that normally there occurs antiperistalsis which begins about the middle of the transverse colon and progresses backward to the cecum, a mechanism for retention of the heavy liquid feces until the water has been absorbed.

With an abnormally mobile cecum, with a narrowly attached mesentery or congenital bands attached to the viscera or to the parietal peritoneum, this load must be carried by such structures while the patient is in an upright position. The fact that many of these people are completely relieved of their symptoms during pregnancy, due to the bowel resting upon the plateau of the uterus as it rises out of the pelvis, and the load is no longer carried by tension on the mesentery, is a common observation, worthy of note. We have all seen at operations, many times, the cecum lying upon the bony floor of the pelvis, where ptosis of proximal colon is marked, and the patient having no symptoms relative thereto, because the load rests upon the bony pelvis and is not suspended by the mesentery.

Kantor and his coworkers at the Presbyterian Hospital in New York reviewed the record of 959 gastro-intestinal cases. They discovered cecal stasis in 27 per cent. In the cases of stasis they found that the symptoms of headaches, vomiting, right lower quadrant pain and right lower quadrant tenderness were from one and one-half to over two times as high in the low ceca group as in the normal, or high ceca group. Hirsch's work in 1924 on the cecocolic sphincter is significant, but time is not available to go into details.

Operation for the removal of the appendix following a diagnosis of chronic appendicitis does not give satisfactory results.

A fair average of the reports from our leading clinics would place this operation in the best hands, as a failure in about 50 per cent of the cases. It is not the intent here to carry the impression that all of these failures are due to an abnormally mobile cecum and ascending colon, but there is no doubt that many of them can be explained upon



Fig. 1



Fig. 2

Fig. 1.—The abnormally mobile ascending colon and cecum have been lifted out of the abdomen, revealing the true mesentery (A) with its arches of blood vessels and the opaque, nonvascular false mesentery (B). (After Waugh.)

Fig. 2.—Showing the line of incision along the junction of the true and false mesenteries. (After Waugh.)

this basis. Finally, the simple colexy, according to the method of the English surgeon, Waugh, relieves tension on the mesentery and cures a sufficient number of these troublesome patients to warrant its further use until something better is offered.

TECHNIQUE OF OPERATION

Upon opening the abdomen an exploration is made for the more usually recognized pathology. A thorough search for the prevalent abnormal congenital bands is often awarded by positive findings. The most common band is one that extends from the right side of the omentum attached to the ascending colon and to the lumbar region. Other abdominal bands will not be detailed in this paper for lack of space. Any congenital band is dealt with according to indications.

Upon picking up the cecum and ascending colon, one finds that it comes outside of the abdomen. Inspection of the outer side of its true mesentery will reveal a fascial extension drawn out from the lumbar region, and has been called a pseudo-mesentery. This fascial sheet varies in extent with the amount of drag on the lumbar fascia, and in length and thickness with the degree of mobility of the right colon and the age of the patient, respectively. This statement holds, however, only when there is some degree of fixation of the colon at the hepatic flexure.

As illustrated in Figures 1 and 2, this fascia is separated from the true mesentery, and after a space has been made in the lumbar region for the ascending colon the edge of the fascia is sutured to the anterior longitudinal line of the ascending colon. Small and necessary variations in the exact technique will vary in individual cases and with the mechanical acumen of the operator.

RESULTS RECORDED IN THE LITERATURE

In 1920 Waugh reported in detail his results in 180 cases of colexy, according to the method



Fig. 3

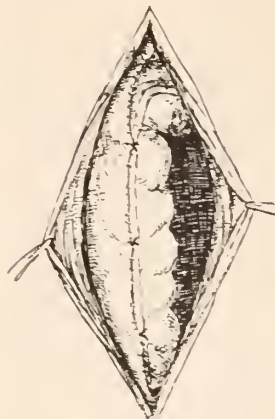


Fig. 4

Fig. 3.—The false mesentery has been turned outwards, exposing above the lower pole of the kidney, on the inner side the ureter, and, crossing the quadratus lumborum muscle, the iliohypogastric, ilioinguinal, and external cutaneous nerves. (After Waugh.)

Fig. 4.—The ascending colon and cecum having been rolled into the extraperitoneal space, the cut edge of the false mesentery has been stitched to the anterior longitudinal band. (After Waugh.)

just shown. It was at this time that we first became interested in this subject, and apparently many others were stimulated by the same article, as recently there have occurred in the literature several reports of work which was started about that date. Altogether, to date, Waugh has reported 518 cases with cures between 75 and 80 per cent, improvement in about 12 per cent, and failures in from 8 to 10 per cent.

Carslaw of Glasgow states that he received his stimulus from Waugh's paper and undertook to operate upon any medical failures suffering from ptosis, as a piece of research work. Over a period of seven years he operated upon 242 cases according to the method of Waugh. He reports that he has followed up 239 of these, and either saw them himself or communicated with their family physician, who saw them. He reports a cure in 70.7 per cent of the cases, much improvement in 18.4 per cent, and failures in 10.9 per cent. Among these were many who were suffering from general visceroptosis, and upon whom he operated, and it was in this group that he met with the greatest percentage of failures. Ten of his patients had previously been appendectomized without relief, and were completely cured by the colepexy. His article amounts to a monograph on the subject, and is very well done.

McConnell and Hardeman of Dublin, Ainsworth of Waco, Texas, Quain of Bismark, North Dakota, and others, have reported results similar to the results of Waugh and Carslaw. Houston of Augusta, Georgia, an internist, has, since 1920, had 145 colepexies performed; and while he does not give a percentage of cures or failures in figures, he states that the results are far more satisfactory than the results following plastic operations in gynecology. This certainly coincides with my experience. He further states that it makes it possible for him as a medical man to keep well, and at work after operation, patients who, before operation, would have periodic breakdowns and

have to discontinue their occupation for a rest cure. Twenty of his patients had previously been appendectomized without relief, and were relieved by colon fixation.

AUTHOR'S EXPERIENCE

Of the colon fixations which we have done in the past fourteen years, we have been able to follow sixty-nine patients. A duodenojejunoscopy and fixation were done in three because of the enormously dilated duodenum. A general plastic, consisting of shortening of the gastrohepatic ligament, fixation of the transverse colon through the omentum to the anterior abdominal wall and a right colon fixation was done in one patient with general visceroptosis, who had been bedridden for fifteen months and who has been well now for seven and one-half years, working steadily as a jeweler. Out of the sixty-nine cases, we can report sixty-three who are relieved of the abdominal symptoms of which they complained; four are very much improved and two are failures. The patients placed in the improved group have all been patients who had a very long transverse and descending colon and, while they are relieved of the dragging type of pain in the right side of their abdomen, they still have, at times, abdominal pains which are relieved by enemas. One of the failures was a young girl about seventeen years of age, operated upon for acute appendicitis and who had a gangrenous appendix, and because of continued right-sided chronic aching type of pain, two years later she was reoperated upon and a colon fixation done. She is still constipated, has indigestion, headaches, is of a very nervous type in spite of the fact that she is quite plump, she still complains of a great deal of right-sided abdominal pain. Urological search and other examinations have failed to find the cause of her pain.

Our other failure occurred in a woman about forty-five years of age, who had previously had an ovariectomy, an appendectomy and a cholecystectomy at different operations, and many operations for fissure of the anus. She was of the biliary type, and has marked colitis; and while her medical man maintains that he thinks she has definitely been benefited, she still has many complaints when she talks to me.

We have been mindful all the while that this is a subject upon which one could easily go astray because there are many patients who have abnormal mobility of the right colon who do not have any symptoms whatsoever as a result thereof, and in operating, even though an abnormally mobile cecum and ascending colon were present, and at the time of the operation other pathology found which would explain the patient's symptoms, the colepexy has not been done. There have been several cases with mobile ascending colon in whom a large-mouthed, kinked appendix, containing enteroliths, have been removed and who have come back complaining of a dull aching pain in the right side, and whom we believe would have been relieved had a colepexy been done, although at the time of the operation it was thought that the condition of the appendix was sufficient to explain the symptoms.

The operation is simple, easy to perform, adds only about ten minutes to the operating time, is not destructive—on the contrary, is constructive and is based, I believe, upon sound physiologic principles. It does not increase the number of operations, as these patients are recruited from those (medical failures) whose symptoms cause them to be opened for chronic appendicitis, questionable gall-bladder, ulcers, exploratory, etc.

IN CONCLUSION

The subject is too big to try to cover in a short paper, but, in conclusion, we would like to say, with Houston, that we believe if those who are interested will refer to Waugh's original essay on his 180 cases in the *British Journal of Surgery*, 1920; to McConnell and Hardeman's essay in the same journal, 1924; and again in the same journal of 1928, to Carslaw's long article reporting 242 cases of colepepy as studied in Glasgow; and further if he will familiarize himself with the mass of literature on the subject in the light of physiology, he will inevitably come to the conclusion that some of the most troublesome patients fall in this group, and that many of them can be cured by fixing the ascending colon in its normal position.

2000 Van Ness Avenue.

DISCUSSION

LOREN R. CHANDLER, M. D. (Stanford University Hospital, San Francisco).—Doctor Brooks has reviewed excellently the clinical aspects of mobile cecum, and his experience with the Waugh operation shows a high percentage of cures. However, I disagree sharply with him on his interpretation of how symptoms are produced, and upon the treatment indicated to relieve these patients of their complaints.

The abnormal bands referred to undoubtedly are congenital. They are present in a large number of infants and new-born, and have such a regularity in their position that it seems unlikely that they could be produced so exactly and frequently by intra-abdominal inflammation. The bands are always attached to the anterior longitudinal band of the ascending colon, a short distance below the hepatic flexure, and extend laterally and upward to the parietal peritoneum below the lower pole of the right kidney. They are lateral and anterior to the true peritoneal mesentery of the colon. These bands also may extend from these two limits to other points, involving the duodenum and gall-bladder and, in some cases, the visceral attachment of the band extends cephalad onto the terminal portion of the small bowel. But no matter what else is involved, the attachment to the colon is to the anterior longitudinal band. Inasmuch as the parietal attachment is above and behind the visceral attachment, these bands do not pull on the mesentery of the colon or small bowel, but tend to pull the point of attachment on the colon backward, and rotate it laterally. This leaves the cecum and that portion of the ascending colon proximal to the point of fixation unusually free and mobile.

Many persons possess these bands, but do not have symptoms. Careful observation reveals the fact that when these bands are short the ascending colon is partially obstructed and rotated laterally at the point of attachment of the band. Patients with this condition have the symptoms so well described by Doctor Brooks and others. When these bands are long and there is no obstruction or rotation (and this condition is found a great many times), the patients do not have abdominal symptoms. The partial obstruction produces stasis and must interfere with normal physiology; but I have never been convinced that "traction on the narrowly attached mesentery and/or abnormal bands upsets the normal physiology of the autonomic nervous system"—in such a way as to cause this type of intestinal complaint.

Inasmuch as the symptoms are due to obstruction, the treatment is to relieve the obstruction. This is done by sectioning the abnormal band at or near its attachment to the parietal peritoneum. This relieves the obstruction promptly and, I believe, permanently. The Waugh operation separates the attachments of the band, which I believe produces the cure, but goes further in that the abnormally mobile cecum and lower part, of the ascending colon are sutured to the fascia of the posterior abdominal wall. This part of the Waugh operation is unnecessary to effect a cure.

Although I am not aware of any definite symptom-complex or syndrome in these patients, I agree with Doctor Brooks that this condition is a very definite entity which can be cured by operation.

✽

JOHN M. SCHMOELE, M. D. (1930 Wilshire Boulevard, Los Angeles).—Doctor Brooks's paper deserves intensive study by all clinicians and surgeons. The problem of the mobile right colon, associated with congenital bands of various types and anatomical positions, is still somewhat of an enigma to most of us; yet, after studying the observations of the author, Waugh, Rea Smith, McConnell, Carslaw, and others, one must feel that this solution is at least in sight.

I have had the opportunity to be associated during the past decade with the late Dr. Rea Smith, who carried on a great amount of practical work in this field, paying especial attention to the relationship between chronic arthritis and toxic intestinal absorption, resulting from congenital malposition and bands blocking the right colon. A right-sided colectomy was performed with the Lane short circuit in the beginning. This series included over one hundred cases. The Waugh operation was done later, but during the past seven years the opaque avascular false mesentery or band was simply excised and the bowel supported externally by properly fitting abdominal supports.

The chemistry and physiology of the right bowel following any type of reconstructive surgery must be considered if relief of symptoms are to be expected with relative rapidity. The intestinal flora should be studied, peristalsis stimulated, and rigid attention paid to diet.

Doctor Brooks, for want of space, has not stressed sufficiently the importance of detailed roentgenologic studies in making the diagnosis of abnormalities of the right colon. (I refer to a technique developed by Taylor. (*Journal of Bone and Joint Surgery*, Vol. 10, No. 1, pp. 62-68, January, 1928).)

Our clinical results have been tabulated primarily on the basis of symptomatic relief of chronic arthritis rather than the relief of gastro-intestinal symptoms, which we have considered secondarily. It suffices at this time to say that our results have been clinically satisfactory, although our experience with the Waugh operation does not warrant an authoritative criticism.

✽

WILLIAM L. BENDER, M. D. (384 Post Street, San Francisco).—Mechanical abnormalities of the colon are frequent, in the distal as well as the proximal portion. For some time I have been interested in the symptoms due to unusually long or redundant sigmoid colon. Opinions differ as to the acquired or congenital status of this condition. Therapeutically, one should bear in mind that obstruction or stagnation distally may influence the result of operation to relieve the condition described by Doctor Brooks, through back pressure. Since developmental anomalies tend to be multiple, the gastro-intestinal examination should be cognizant of others, such as diverticula, including Meckel's, and diaphragmatic abnormalities. On the whole, the reported results of colepepy are good, and unquestionably the procedure deserves the emphasis Doctor Brooks places on it.

✽

DOCTOR BROOKS (Closing).—I wish to thank Doctors Chandler, Schmoele, and Bender for their discussion of this paper. I am in entire agreement with Doctor Chandler in reference to the band that he describes as being congenital. He is also correct in his description of its attachment or probable attachment. It is accepted that this band represents a lateral extension of the omentum. In fact, its blood supply is continuous with that of the

omentum, and, so far as I know, no one who is informed any longer contends that it is of inflammatory origin. Moreover, the band often only extends to the ascending colon and does not cross this portion of the gut, and is not necessarily attached in the lumbar region. The band may or may not be responsible for partial obstruction, and may or may not, therefore, cause any symptoms.

I do wish, however, to take issue with Doctor Chandler when he infers that this particular band is necessary for the production of the chain of symptoms outlined in this paper, for the excellent reason that the majority of the patients under discussion here, and in the experience of others, did not have this particular band, and did have the symptoms outlined and were relieved by operation. I am convinced that the right lower quadrant discomfort or right lower quadrant pain is due to a distention of the cecum, whether the distention is caused by partial mechanical obstruction or by functional stasis without mechanical obstruction, except that, clinically, with mechanical obstruction the symptoms are apt to be more constant than the variable symptoms in the cases with functional stasis.

I did not state in this paper that this congenital band pulled on the mesentery. The fact is that some congenital bands that take part in disturbing the autonomic nervous system do so by pulling on their attachment to the parietal peritoneum. A slight pull on the parietal peritoneum through a congenital band, or a pull on the mesentery by the weight of a filled cecum, does definitely disturb the sympathetic part of the autonomic nervous system. This fact can be definitely and easily demonstrated at operation under local anesthesia, and confirmed by irrefutable evidence presented in all standard textbooks of physiology. This paper was meant primarily to deal with the chain of symptoms or clinical entity based, in my opinion, upon morbid or pathologic physiology and not so much as in the usual surgical lesions on deadhouse pathology.

I believe there is a definite relationship between stagnation of the cecum with absorption of bacteria with increased virulence and progressive arthritis in people with advancing years. I am indebted to Doctor Schmoele for bringing out this point. Time and space did not permit of the discussion of this aspect of the subject at this time. However, it is propitious to say here that if there is a definite relationship between cecal stasis and arthritis, it should be important to relieve the stasis of the cecum by whatever means necessary and prevent or slow down the development of the multiple arthritis.

Likewise, Doctor Bender brings up an important point relative to congenital abnormalities often being multiple, all of which may have a definite significance in any given case; but a general discussion of these complications to right mobile colon could not be crowded into the time allotted to this paper.

CONGENITAL OCCLUSION OF THE SMALL INTESTINE*

By JOHN HOMER WOOLSEY, M.D.
Woodland

DISCUSSION by E. Eric Larson, M.D., Los Angeles; William J. Norris, M.D., Los Angeles; Edwin M. Taylor, M.D., Oakland.

CONGENITAL occlusion of the small intestine occurs from both intrinsic and extrinsic causes; in single and multiple forms; and chiefly in the duodenal and ileal regions. Its frequency merits attention. It can be diagnosed and is amenable to surgical correction. Newer ideas of stool examination and proved methods of roentgen-ray study aid tremendously in its recognition, location,

and degree of occlusion. Proved and clever methods in technique aid greatly in the operative treatment.

ETIOLOGY

One would think that occlusion would occur at the site of junction of the embryologic portions of the primary gastro-intestinal tract, such as the junction of the fore- and midgut, and the mid- and hind-gut; but this is not so. Also the often-quoted remark of Bland Sutton of 1889, "always in the situation of embryological events," is not strictly true. The occlusion occurs from both intrinsic and extrinsic causes, and these causes play a part in the location of the occlusion.

Intrinsic Causes.—The intrinsic, as recognized today, was described in 1900 by Tandler¹ and more completely in 1907 by Forsner,² a Swedish anatomist. They observed that up to the fifth week of fetal life the small intestine presents a well-defined lumen lined with epithelium; that these epithelial cells rapidly proliferate and obliterate the lumen by epithelial conrescences. By the twelfth week of fetal life these conrescences break down into a liquid state, forming vacuoles which in turn coalesce and reestablish the lumen. If, on the contrary, some interference in development occurs during this period, an atresia or a stenosis may result. Forsner divides the mal-developments into three groups, namely, Group 1, in which a small diaphragm of epithelial cells, either complete or incomplete, occurs across the lumen, thereby giving a complete or partial occlusion; Group 2, in which there are two blind ends of intestine joined by an intervening cord, known as an atresia; and Group 3, in which there are two blind ends of the intestine absolutely unconnected—also an atresia.

Extrinsic Causes.—The extrinsic causes are those due to a sclerosis of the blood vessels to a local area with a resultant lack of development because of insufficient blood supply; to mal-development of the vitello-intestinal duct, in that if atrophy of this embryologic tract goes on to excess it absorbs some of the primitive bowel, giving either a stenosis or an atresia; and to faulty rotation of the intestine with compression of the blood supply and a secondary loss of development.

Faulty rotation is considered to be a cause of abnormal conditions in the lower ileum. Faulty rotation may present a disturbance at many levels due to compression of a local blood supply from a constricting fibrous band, from overfusion of a mesentery, or from a volvulus. The normal embryologic process of development and rotation of the small intestine is somewhat as follows: After the fifth week of fetal life, the liver and other visceral organs grow faster than the abdominal cavity, and the midgut is forced into the base of the umbilical cord. By the tenth week the midgut begins its return, with the duodenal, jejunal and upper ileal segments being first. As they return they pass in sequence from the right to the left behind the superior mesenteric artery. This leaves, as the last loop to return, the lower ileum, cecum,

* From the Surgical Service of the Woodland Clinic.

Read before the General Surgery Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

the ascending colon, and a portion of the transverse colon. In this final loop the apex is formed by the vitello-intestinal duct, later known, when it persists in a blind pouch, as Meckel's diverticulum. As the final loop returns to the abdominal cavity, it crosses from left to right in front of the superior mesenteric artery, and its mesentery becomes fused with the posterior parietal peritoneum, thereby giving the firm attachment of the right-sided portion of the large intestine and the oblique left to right of the lower small intestine. An arrest of development at any stage is a potential volvulus, hernia, or constriction of the blood supply by pressure from faulty rotation or by fibrous bands.

INCIDENCE

Occlusion of the small intestine is most often single, but occurs sufficiently multiple—15 to 19 per cent, to demand a thorough inspection of the entire intestinal tract at operation. They are most common in the duodenum, more especially in the region of the ampulla, and in the ileum at the embryologic site of the vitello-intestinal duct. They are quite common at the ileocecal valve region, and do occasionally occur in the jejunal and upper ileal positions.

A summary of reports of a few series of collected cases shows that approximately 44 per cent occur in the duodenal region, 18 per cent in the jejunal region, 37 per cent in the ileal region, and 19 per cent were multiple.

In the duodenal area, occlusions occur chiefly in the ampullary region and are about equally divided as to location above and below the ampulla.

DIAGNOSIS

The clinical findings depend upon the location and the degree of the occlusion. Ordinarily the symptoms occur in the first six days, and begin in the first twenty-four hours. An atresia will give a prompt onset, but a stenosis may be so mild as to allow the child to retain the majority of the food and go on to even adult life before sufficient disturbance occurs to demand surgical investigation.

Regurgitation or vomiting, at times projectile in character, is the first symptom of importance. As a rule, gastric distention is present, and deep peristaltic waves are often observable. If the occlusion is in the ileal region, a more general distention will occur. Loss of weight and dehydration are other signs that follow.

One should always look for the passage of meconium. If continued vomiting occurs, microscopic examination, as described by Farber⁹ in 1933, should be made. Meconium appears in the intestinal tract at about the third month of fetal life. It is composed of the amniotic fluid, and its contents are derived from the skin of the fetus, namely, vernix caseosa, lanugo hair and cornified epithelial cells, also bile, pancreatic secretion, intestinal secretion, and desquamated intestinal epithelium. The cornified epithelial cells have, as their only source, the skin of the fetus, and if a

microscopic study of the meconium shows an absence of these cells, there is somewhere between the mouth and the anus a complete occlusion of the gastro-intestinal tract. Farber suggests the following routine for this examination:

1. Make a thin smear of meconium on a glass slide.
2. Place the slide, either immediately or when dry, in a dish containing ether for one to five minutes, until fatty substances disappear.
3. Dry in air for a few seconds.
4. Stain for one minute with Sterling's gentian violet (or better, methyl violet).
5. Wash in running water.
6. Decolorize with acid alcohol.
7. Dry and examine.

He states that the cornified cells stain blue, while all other cells are decolorized.

Roentgen examination, both with and without contrast medium, is of great assistance, and in fact may make the diagnosis. A plain plate of the abdomen will often outline the point of occlusion by the presence of gas to a certain point, in contrast to absence of gas generally. The use of contrast medium, we believe, is not fraught with danger, provided one gives a minimum amount. The x-ray findings without contrast medium are more valuable in an atresia, but with a contrast medium a stenosis is more likely to be demonstrated. An exact diagnosis is most important in directing the treatment, for it is desirable to avoid all unnecessary exposure in an abdominal exploration and to perform quickly whatever surgical procedure is indicated. The exact location of the occlusion, and the differentiation between an atresia and a stenosis directs the surgeon to the site of the trouble and give him definite information as to where he should or can make the new anastomosis.

Differential Diagnosis.—The differential diagnosis lies in distinguishing chiefly between the more common obstruction of a congenital hypertrophied pyloric muscle, which occurs usually after the twelfth day rather than during the first six days; an obstruction of the esophagus, demonstrable by x-ray; an occlusion of the large intestine, demonstrable by the degree of general abdominal distention and x-ray studies; an imperforate anus, diagnosed by physical examination; and vomiting from a so-called functional cause, which is usually controlled by atropin and thick feeding.

It is true that intestinal occlusion is rare; but with vomiting in the newborn it is always mandatory to prove, before the little patient reaches the stage of exhaustion from starvation and dehydration, that it is not on a mechanical basis that may be corrected.

TREATMENT

Early diagnosis and prompt treatment is of vital importance. Primarily the patient, who as a rule is somewhat dehydrated, should first be supported with adequate amounts of subcutaneous fluids.

TECHNIQUE

Anesthesia should be either local infiltration, supplemented by a small amount of ether by open

mask during the intra-abdominal surgery; or ether during the entire procedure.

An upper or mid-right rectus incision gives the best exposure, and may be enlarged as desired. The more exact the diagnosis the more direct the treatment may be; but under any circumstances a rapid palpatory exploration of the sigmoid and of the transverse and ascending colon should be made. The small intestine should then be inspected visually throughout its entire extent for the presence of multiple occlusions.

In any of the occlusions, except those occurring by faulty rotation, an entero-enterostomy or a gastrojejunostomy when indicated, is the procedure of choice. In the past the majority of ileal occlusions have been treated by an enterostomy, and almost universally the patients have died. It is believed that the deaths were, however, due in part to late surgery and to the failure to employ parenteral fluids. If the occlusion is in the duodenal or duodenojejunal region and is complete, a duodenojejunostomy is the procedure of choice; and even if incomplete, this treatment is probably the more satisfactory. Frequently a gastrojejunostomy performed for the high and complete occlusions has been followed by continued, though modified distress, and later a duodenojejunostomy has been necessary to give complete relief. A gastro-jejunostomy, on the other hand, is far easier to do, will as a rule tide the patient over to a safer age for surgery, and in the stenotic form is in the majority of instances just as satisfactory. Occlusions from the jejunum to the colon are best treated by entero-enterostomy.

Technique.—The technique of these operative procedures is very important. Open anastomosis without clamps is the procedure recommended. The two portions of the gastro-intestinal tract to be anastomosed are brought into apposition. A black silk suture is taken at either end through both portions and held taut as guy supports by the assistant. All other viscera are replaced if necessary into the abdominal cavity and securely held there by moist gauze sponges, with only the portion to be anastomosed exposed. For the outer layer, interrupted silk sutures are employed, and for the inner a running suture of double 0 plain catgut intestinal suture, swedged on the atraumatic needle. This method gives definite knowledge that the anastomosis is patent; avoids too much turning in of the anastomosed edges; gives adequate support until healing is completed; causes the least trauma to the tissues; and prevents shock by a minimum amount of exposure.

Always in an atresia, and occasionally in a stenosis, the intestine below the site of occlusion is collapsed. The size of the lumen is such as to make one wonder if it will ever function. The author has recently noted a similar appearance in an adult where the ileum, unused for two years, was collapsed to a ribbon appearance, and yet was distensible to a seven-centimeter diameter. In 1904, Clogg suggested that, before proceeding with the anastomosis, the collapsed bowel be distended with fluid or air. In 1933, Ladd suggested

the use of a catheter inserted in the lower collapsed segment and the suturing of the anastomosis over this. The distention of the collapsed loop with sterile water or normal salt solution not only enlarges the bowel for the surgery and demonstrates its patency, but provides additional fluid which is necessary and can be promptly absorbed.

The subject of the handling of an obstruction caused by faulty rotation will be discussed in other papers to be read at this meeting. In addition, an excellent article by Ladd in 1933 is recommended.

Prognosis.—The prognosis for the successful treatment of occlusion of the small intestine should not be judged upon the past experiences of the profession. Proper preparation with fluids, early and definite diagnosis, atraumatic technique, and parenteral fluids postoperatively, as well as an intelligent use of breast milk or formula, should raise the percentage of successfully treated patients. The first successful cases were reported in 1911 by Fockens, a Dutch surgeon; in 1916 by Ernst, an English surgeon; and of especial interest to us, a case in 1916 by Alanson Weeks of San Francisco.

REPORT OF CASE

Another successful case is hereby reported.

W. C. H. No. 39072. A male infant from the third postnatal day regurgitated and later vomited much of the food taken, and bile-stained fluid. By the twelfth day a loss of twenty-five ounces in weight had occurred. Meconium had been passed. Varied formulas and atropin had been employed. Physical examination demonstrated a laxness of tissues from weight loss and moderate dehydration, a slightly distended stomach, marked gastric peristaltic waves from left to right, and a patent anus. A tentative diagnosis of congenital hypertrophy of the pylorus was made and an x-ray investigation was begun.

Barium sulphate was given by mouth and there was demonstrated a marked dilatation of the stomach and hyperactive peristalsis with the waves passing through the antrum, a patent pylorus, and a hugely dilated duodenum, ending abruptly in the fourth portion. At the end of one hour a very narrow lumen at the point of obstruction was demonstrable in the film. A diagnosis of partial occlusion at the duodenojejunal junction was made.

After preparation with parenteral fluids, a celiotomy by right rectus incision was made. Anesthesia was obtained by local infiltration until the abdominal cavity was opened and then a small amount of ether on the open mask was employed. The operative findings were as follows: The stomach, and especially the pyloric muscle, were entirely normal in size; the intestines were in their normal positions; the duodenum was dilated to eight times normal, approximately 4 centimeters in diameter; the jejunum and ileum were extremely small, approximately .5 centimeter in diameter and of even caliber throughout; and the large intestine visible in the upper extent, and palpated in the lower extent, was entirely complete and measured approximately .75 centimeter in diameter. The site of the occlusion was not seen, as it lay behind the stomach.

Since there was sufficient opening to allow the digestive juices of the duodenal area to pass down their normal course, and because of the easier procedure, a posterior isoperistaltic gastrojejunostomy was performed according to the method and technique previously described.

Parenteral fluids were given for the first two days postoperatively, and formula was fed as for a congenital pyloric stenosis. During the first twenty-four hours the infant retained 50 per cent of the intake, and all thereafter. At operation the weight was six pounds, and on the seventeenth day, when discharged from the hospital, the weight was eight pounds five ounces. He has never had any further abdominal distress, has been normal in

every respect, and weighed twelve and one-half pounds at three months. An x-ray examination with barium sulphate demonstrated that the stomach empties at a normal rate by the gastrojejunostomy stoma. No barium was observed to pass through the pylorus and duodenum.

CONCLUSIONS

Congenital occlusion of the small intestine is caused by intrinsic and extrinsic embryologic maldevelopments. It presents its symptoms in the first six days of life. Stool examination and roentgen-ray examination may demonstrate important findings. It may occur in multiple form, and it is amenable to treatment. The treatment consists of the intelligent use of parenteral fluids pre- and postoperatively; thorough abdominal exploration; the employ of atraumatic technique; and an anastomosis rather than an enterostomy.

A case of congenital partial occlusion of the small intestine at the duodenojejunal area, successfully treated, is reported.

Woodland Clinic.

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DISCUSSION

E. ERIC LARSON, M. D. (1930 Wilshire Boulevard, Los Angeles).—Doctor Woolsey has presented to us one of the interesting problems relative to the surgery of infants.

Not many general surgeons have the opportunity of seeing such an unusual problem nor treating such a patient. His report of a successfully treated patient with stenosis high in the gastro-intestinal tract is most commendable.

I recently treated, unsuccessfully, an infant with atresia situated high in the ileum. There was interposed a flat transparent ribbon, three centimeters in length. I had never seen such a condition, and can assure you that the technical difficulties incident to short-circuiting a distended loop to an unused loop distal to the atresia was most trying. My little patient died, and an autopsy was refused.

Should I ever encounter such a problem again, the author's suggestions relative to diagnosis and preoperative and postoperative care, would be scrupulously heeded. The distention of the distal intestinal loop with saline solution, to insure fluid to the patient and more careful approximation of the enterostomy openings with the atraumatic suture, would be done. I remember very clearly the small apertures left around each suture puncture in the distal loop, and that I felt certain that leakage would endanger my patient's life, which it undoubtedly did.

Doctor Woolsey further calls attention to the high percentage of multiple lesions. A successful operation for the defect, with the failure to recognize other similar lesion, would be gross negligence. It is mandatory that we surgeons operating on infants must know embryology and the usual defects that may occur. The examination, recognition and repair of these defects must be done with the least trauma possible.

✱

WILLIAM J. NORRIS, M. D. (1136 West Sixth Street, Los Angeles).—The entire intestine may be absent or shortened, but not lengthened. In rare cases a fistula may

communicate with the abdominal wall. This may be a helpful factor in tiding the case over until a more suitable time for operation.

My only experience with such a case was an infant, two weeks or more premature, who entered the hospital when three days of age, weighing four pounds and ten ounces. Since birth there had been no bowel movement. The infant had repeatedly regurgitated dark-colored and bile-stained material. Dehydration was marked, and the patient was moderately jaundiced. Rectal examination was normal. X-ray examination showed the presence of an obstruction in the first portion of the jejunum.

Fluids were supplied freely subcutaneously for twenty-four hours before operation. An attempt was then made to wash out the barium which had been given by mouth.

An upper rectus incision was made. The jejunum, about six inches from the ligament of Trietz, was found to end in a fibrous cord. This cord was not attached to the distal portion of the jejunum, which was found as a blind pouch adjacent to the free end of the fibrous cord. The stomach, duodenum, and first six inches of the jejunum were greatly dilated, thickened, and filled with secretion and barium. The distal end of the jejunum was approximately one-half centimeter in diameter.

Had I read Doctor Woolsey's paper before the operation, I would have tried to do an anastomosis. Instead, a large catheter was inserted into the proximal end of the jejunum, and a small catheter into the distal end of the jejunum. These were brought out of the upper end of the abdominal incision. The hope was to allow an opportunity for getting rid of the barium in the stomach, and for the child's general condition to improve.

For two days the patient's condition seemed remarkably good. It then grew worse. The infant expired on the fifth postoperative day.

At postmortem a localized fibrinopurulent exudate was found around the site from which the tubes emerged. The average diameter of the duodenum was two centimeters and of the small intestine and colon, eight-tenths of a centimeter.

Dr. Frank Matthews of New York City kept alive, for one year, a patient with atresia of the terminal ileum by allowing the terminal ileum to drain through the abdominal wall.

Dr. J. Norton Nichols of Los Angeles cared for twins with atresia of the terminal ileum.

May I stress particularly the method of diagnosing complete obstruction mentioned by the author and described so ably in the article to which he referred?

Had a microscopic examination of the feces in my own case been made before the barium mixture had been given, I feel sure that the complication of so much material in the stomach and duodenum would have been avoided.

✱

EDWIN M. TAYLOR, M. D. (230 Grand Avenue, Oakland).—As Doctor Woolsey has pointed out, congenital occlusion of the intestinal tract may be in many locations, due to the many causes stated.

Early diagnosis, the proper preoperative preparation of the patient, and early surgery, are of paramount importance. As we rarely find the same condition present in any two patients, what is to be done must be left to the judgment of the surgeon.

Surgery in the new-born is hazardous, so the least difficult procedures are the method of choice. The fact that anomalies are often multiple must always be kept in mind by the surgeon.

May I present the summary of a case with the autopsy report of Dr. Paul Michaels from the Children's Hospital of Oakland?

J. C., four days old. Had been vomiting for three days. Passed some meconium after birth. At surgery a distended small bowel down to a Mechel's diverticulum was found; bowel below very small. Catheter was placed in Mechel's diverticulum. The patient died five weeks later.

Autopsy: Entire colon atretic, also terminal 18 centimeters of ileum (size .75 to 1 centimeter in diameter). The remaining proximal ileum distended. Diverticulum 30 centimeters in length. The distal end was free. There was no peritonitis and no other congenital anomalies.

SINUS DISEASES: THE USE OF ROENTGEN RAY IN THEIR DIAGNOSES*

By ORRIE E. GHRIST, M.D.
Glendale

DISCUSSION by Dean E. Godwin, M.D., Long Beach;
Harold A. Fletcher, M.D., San Francisco; Charles E.
Futch, M.D., Los Angeles.

HISTORY

IN passing currents from one electric pole to another, it is probable that William Morgan, in 1785, produced the first x-ray, but he certainly was not cognizant of the fact.

The first to recognize that he was dealing with these rays was William Konrad Roentgen of Würzburg, Bavaria. In 1895 this investigator was doing extensive experimental work on the passage of electric current within an evacuated tube. He first noted a strange phenomenon: in a dark room with the tube covered with light opaque material, passage of current within the tube would cause a platino barium cyanid screen nine feet away to fluoresce. During these experiments, one day he was called quickly out of the room. He happened to lay this tube on a book, which book contained a large key under which lay a photographic plate (we know now that in the older type of tubes x-rays were emitted for a time after the current was turned off). He later took a hike, during which he used this film to take a picture. On developing it he noted the outline of this key. He repeated the experiment, and again found the outline, and realized he was dealing with some ray, invisible to the naked eye, and capable of penetrating matter which was opaque to the ordinary light rays.

Because he did not recognize this ray he called it "X" ray. He later laid his hand on a plate and was the first to demonstrate bony shadows on an x-ray plate. He was also the first to show the shadows on a fluorescent screen. It is noteworthy that within a year it was being used in medicine in many places in Europe and America. Four days after its introduction in the United States a bullet in the calf of a man's leg was located.

Sheir, in 1897 (only two years after its discovery), was the first rhinologist to demonstrate that a sinus, which appeared flat on an x-ray plate, contained pus.

PROPERTIES OF ROENTGEN RAYS

Some of the interesting things about roentgen rays are as follows:

If we consider them in relation to the visible spectrum (8000 Angstrom units for red to 4000 Angstrom units for violet), we find they are of much shorter wave length (1000 Angstrom units to 0.06 Angstrom unit), and are to be located in the electromagnetic spectrum far out beyond the violet and ultra-violet rays.

They travel at the speed of light (186,000 miles per second).

They cannot be deflected by a magnet.

It was thought that they could neither be reflected nor refracted, but we now know they can be diffracted and reflected by certain crystals. Seigbahn has obtained a spectrum of x-rays, and it is on this work that the science of crystal analysis is based.

They have certain biologic effects. Depending on the amount of absorption by the cells, they will cause either stimulation, retardation in growth, or complete destruction.

They ionize gases.

Chemically, they cause certain actions: for example, they cause iodine to be freed from iodoform in chloroform.

Those properties which are of especial importance to physicians are:

1. They cause a fluorescence of a platino barium cyanid screen.

2. They affect photographic plates exactly like light rays.

3. They penetrate matter which is opaque to ordinary light, and they are inhibited from penetrating this matter in direct ratio as to its atomic weight.

This latter characteristic is of special importance because, even though x-rays do spell mystery to the layman, a harvest for the charlatan, and a glowing story for the x-ray salesman, to us they are only showing on a photographic film the differentiations in density of the parts x-rayed. This, above all points, should not be lost sight of.

APPARATUS

There are a number of different head-rests used for holding the head and getting the proper angles. No matter what type you use, there are three essentials:

(a) The head must be held exactly in the mid-line, *i. e.*, in the posterior anterior position; the head must be exactly centered in a vertical line, and the x-ray target must be exactly above this center line.

(b) The glabella-mento line must form a definite angle with the horizontal.

(c) The head must be absolutely still while the view is taken. (Check this by noting if the cancellar bone of the jaw around the teeth, etc., stands out clearly.)

We use a head-rest which Dr. D. M. Ghrist worked out a number of years ago. In our experience, it meets all three of the above requirements and can be used either with or without a Potter-Bucky diaphragm.

The nose fits into an opening in a bakelite plate. This fixes the glabella-mento line. The angle at which this plate rests can be read off at the side on an angle meter. The bar which screws the two bakelite side head holders together is a solid bar clear across, fixed at the mid-point, with threads from both sides, progressing toward the center. Thus, when this is screwed up, the head is fixed in the exact mid-line.

NOMENCLATURE

The nomenclature which eye, ear, nose, and throat specialists and the roentgenologists have in

* Read before the Eye, Ear, Nose and Throat Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25 to 28, 1936.

common is as a rule easily understood, but there is one thing which we should bear in mind, namely, that in describing the position in which a film has been taken the roentgenologist uses such expressions as posterior anterior (or P. A.), etc.

The first in this case, the "P," means that that part is nearest the tube, and the last in this case, "A," is next to the film. In asking the roentgenologist to take certain views, this point should be kept in mind, for he is able to get the best detail in the part nearest the film.

PENETRATION

The first thing to notice about an x-ray film is whether or not it has been correctly exposed, overexposed, or underexposed. This can be told at a glance. Definitely underexposed pictures are very weak and bleached out. One can see that not enough of the x-rays have gotten to the film. Definitely overexposed pictures give a slaty appearance. If either of these two latter characteristics are noted, little or no exact information as to the status of the sinuses can be obtained from reading the films.

FUNDAMENTAL SETTINGS

There are many variations as to the settings chosen by the different roentgenologists. Nowadays so many different schools are turning out x-ray technicians that it is essential for each of us to choose definite settings with which we may become very familiar, and we should know these positions well enough to ask the technician for them. As for example:

"I wish a sterio P. A. (anterior part or face next to the film) of the sinuses at the 40-degree angle, or the 23-degree angle."

It is, of course, preferable merely to say to an expert roentgenologist, "Please make a thorough sinus study"; but even then when one sees the pictures and reads the report, one must have some concept as to their angles and positions.

All settings should be in sterio, except for Granger's "G" line.

You can check the setting used in the posterior anterior positions by noting where the petrous portions of the temporal bones cut across the film.

POSITION.—Views can be taken in either the lying or upright position. In the upright position, if a sinus is partially filled with fluid of low enough surface tension, Claus has demonstrated a concave line. If this line fails to shift when the head is tilted, the sinus content is likely to be mucopurulent. Convex lines are generally polypi.

The settings which seem to get the best results in sinus studies are the following:

The Forty-Degree Angle.—Here we note the petrous bones are below the lower floor of the antrums. This position gives a good view of the antrums (except their floors), a fair view of the frontals, ethmoid areas, and if the proper type of a wooden block is used to hold the tongue down and the mouth open, a third shift of the tube gives a good view of the sphenoid cells in the open mouth.

The Twenty-Three-Degree Angle.—Here the petrous portion of the mastoids go through part

of the antrums. This gives a better view of the frontals especially.

The Seventeen-Degree Angle Below the Horizontal.—This is Granger's view, and is taken to study especially Granger's "G" line of the sphenoids. Here we also get a good view of the posterior ethmoids, and sometimes obtain information on the anterior ethmoids. This view must be accurate. The head must be carefully centered, and the resultant view will be correct only if the petrous bones pass exactly through the center of the orbits.

Verticomenal View.—This view is used very frequently in studying the sphenoids. It gives information especially as to their lateral extensions.

Lateral View.—This view in sterio often shows quite well the condition of the ethmoids, the anterior posterior limit of the sphenoids and any thickening of the floor of the frontals. Here also we especially should notice how thick the skull is, because, of course, the thicker the skull the less intrasinus detail we expect to get in our other views.

Of the above views, we use routinely the sterio of the 40-degree angle, the Granger "G" line and a sterio lateral, using the other views only as indicated.

EFFECTS DIFFERENT PATHOLOGIC PROCESSES HAVE ON ROENTGEN RAYS

In checking the changes to be noted on x-ray films, one should look for:

(a) Comparative cloudiness: for this comparison we use the inner wall of the orbit. Practically speaking, the inner wall of the orbit gives the same density as the inner portion of the normal sinus.

(b) Changes along the sinus walls, *i. e.*, changes in the thickness of the mucous membrane, how sharp the sinus walls stand out, and whether or not they are partially or totally eroded.

The pathology in the sinuses manifests itself on the x-ray films more or less clearly in direct ratio as to the amount the tissues and spaces are changed in their specific gravity.

Sinuses of Unequal Size.—The smaller shows more dense than the larger.

Edema, or water logging, as we see it in acute disease, gives a markedly fuzzy appearance; and when in the mucous membrane also causes a marked blurring of the distinctness of the sinus wall outline. This is especially noted in the posterior anterior views.

Fluids or Pus.—Make the whole sinus look generally more opaque (the higher the specific gravity of the contents the more opaque they appear). At times a fluid line is demonstrable.

Hypertrophies of the Mucous Membrane.—Shows as a thickening inside the sinus walls. As this condition becomes more chronic, and as a certain amount of osteitis progresses, the bony walls become more sharply outlined. As this further progresses, the outline becomes sharper and sharper until the bone is sometimes eroded. Polyps sometimes reveal their outline in these films. (Law.)

Cysts.—Show an increased density and a rounded and smooth outline.

Osteomyelitis.—The important thing to be remembered here is that the x-rays do not, as a rule, show changes in the structure of bone for from eight to twenty-one days after the disease process starts. This should be borne in mind when looking at mastoids; for although one may see the fuzziness of the edema, or general haziness throughout the bone, from pus or fluid, one does not expect to see changes in the structure of the bone until after the eighth to the twenty-first day. As Doctor Beck once told us in discussing osteomyelitis of the skull, "the disease is at least ten days ahead of your x-ray pictures."

New Growths.—How well do we or do we not see them depends on their effect on the bone. Those new growths which are of a bony character and take on calcium, are, of course, very readily discerned. Carcinomas show only from their effect in bony destruction. Their characteristics are that they show cloudiness of the sinus or sinuses, tend to destroy bony walls, and are much more extensive than you would expect from your x-ray findings.

In applying the aforementioned to a sinus (the antrum for example), we find:

1. Normal sinus: Sharp wall outline; no haziness of mucoperiosteum; intrasinus density that of the orbit.

2. Antrum containing fluid of low specific gravity; general dullness; duller than orbit or its fellow sinus; fluid line (sometimes); inner sinus bony wall can still be seen.

3. Pus in sinus: Marked general dullness (flat); markedly duller than orbit or its fellow sinus; inner sinus bony wall cannot still be seen.

4. Acutely inflamed: Fuzzy mucoperiosteum; fuzzy and indistinct bony outline; some opacity.

5. Chronic inflamed sinus: Hypertrophy mucoperiosteum; bony outline sharper; some opacity.

5a. In ethmoids: Sometimes can see these bony outlines sharper than usual; sometimes goes on to a break in the normal bony outline. (Law.)

6. Chronic inflamed sinus in an acute exacerbation: Hypertrophic mucoperiosteum, which appears fuzzy; bony outline quite clear; some opacity.

In the lateral view of the frontals, note the skull thickness. In this view you will note the presence or absence of the frontal sinus. In the absence of the frontals you should see cancellous bone in their place. No amount of pus or granulation tissue will obstruct them in the lateral view.

Note ethmoids especially in this lateral view. If the small cell-wall lines are fragmented, absent, or stand out with exceptional sharpness, it indicates involvement (chronic).

Sphenoid:

Lateral view: This view shows its anterior posterior size. In this view if you see a fuzziness of the anterior sphenoidal wall, this may be just a pathologic condition in the posterior ethmoids.

Verticomenal view: This view shows you best the lateral edges and lateral extensions; also shows

mucoperiosteum thickenings and general dullness or haziness at times. Granger, however, points out that this view (a) does not have positive and readily identified boundary marks; (b) that you cannot make perfect duplicates; (c) that either polyps, a marked hypertrophy of the inferior turbinate or a carcinoma may cause a normal sphenoid cell to appear cloudy.

Granger's "G" line position: This is a view of the upper border of the sphenoid, and it can show any one of the general sinus changes already noted. We find it one of the most important views. Granger states that, with this view, 95 per cent of the sphenoid sinus conditions can be diagnosed.

PROCEDURE IN EXAMINING PICTURES

1. Was the picture over- or underexposed?
2. Was the picture taken at the correct angle? Was head fixed? (Note: Mastoid bones and cancellous bone about the teeth.)
3. Anatomy: In lateral view, note skull thickness. In posterior anterior view, note relative size of sinuses.
4. General density (orbital comparison) (sometimes the reducing glass accentuates this): Fluid, pus.
5. Study mucoperiosteum. Is it fuzzy? Is there any hypertrophy? Are there polyps to be seen?
6. Study bony walls. Are they fuzzy? Is there any increased sharpness? Has there been any or a total erosion?

WHEN SHOULD WE USE ROENTGEN RAYS

They should never be used as the only method of diagnosis of sinus disease. There is a great tendency of the general practitioner, when he suspects sinus trouble, to have one flat view of the sinuses taken, in order, in his mind, to rule out all sinus disease. This should be discouraged, and the general practitioner taught that there is no easy road to the diagnosis of sinus disease.

A glance below at an outline of the study of sinus disease will show that in discarding all but x-rays, we would be bound to have a high percentage of error.

Diagnosis of Sinus Pathology:

History
Direct examination
Transillumination
X-rays
Laboratory data:
Wassermann
Smears
Fluid
Examination
Blood counts, etc.

We, therefore, must relegate x-rays to their proper place. In keeping the above outline in mind, one can see x-ray is only one phase in the diagnosis, and we must never forget that the x-ray films only show changes in the specific gravity of the tissues and sinus contents, nothing more.

However, these changes in density are often very helpful to us, and in certain conditions it seems that it would be wise for us to refer more patients for x-ray study before giving a negative report on their sinus condition. As an example: I have checked one hundred consecutive cases in an arthritis clinic in the Los Angeles County

Hospital, x-raying all of them, and it is interesting to note two things:

First: That thirty of these patients (30 per cent) showed sinus pathology in their films.

Second: That nine of these patients showing sinus pathology on their films gave *no* history of any sinus disease, which might have led me or the general practitioner to suspect sinus trouble.

As you see here, I have often been surprised to find sinus pathology where I did not suspect it from my history and examination.

Especially in the following group of cases x-rays should be taken:

1. Practically all sinus cases before operation.
2. Before making a negative diagnosis in cases being surveyed for focal infection.
3. Chronic discharging ears.
4. Postinfluenza patients not doing well.
5. Chronic bronchitis.
6. Patients suffering from colds persisting after tonsillectomy.
7. Upper toothache when teeth are negative, from dental point of view.
8. Before septum operation when patient complains of anything but occlusion.
9. Cases with high-arch palate and mouth breathers.

IN CONCLUSION

In conclusion, I advise more exact study of exposures and positions, making certain they are correct. The anatomy of the sinuses should be observed.

In general, fuzzy borders show an acute condition, sharper bony outline with thickened mucoperiosteum shows a chronic state, and general haziness indicates fluid or pus.

In osteomyelitis, or when looking for bony structural changes, one should remember that the disease is about eight to twenty-one days ahead of any visible changes to be found on the x-ray film.

Bearing in mind the relative place of x-rays in the field of diagnosis and their physical properties, one will neither expect too much nor too little of them.

143 North Brand Boulevard.

DISCUSSION

DEAN E. GODWIN, M.D. (820 Professional Building, Long Beach).—To the layman, the x-ray, because of its magic and weird properties, represents the possibility of solution of all his uncertainties and ills, and he expects an x-ray picture to give a ready-made diagnosis to any obscure condition much as he would get in a prediction of his "fortune," from a slot machine. Too often a hurried or lazy physician assumes the same attitude, and expects the roentgenologist to solve his problems and do his thinking for him.

Doctor Ghrist has properly evaluated the roentgenogram, making it but one of the several methods of arriving at a diagnosis in sinus conditions, and I note that in his "outline of the study of sinus disease," he puts the x-ray after the history, clinical examination, and transillumination. In many cases, after these are done, the diagnosis is so obvious that the roentgenogram can be omitted. In other cases, when the condition is more obscure, the picture may be the deciding factor in arriving at the diagnosis. Even when the diagnosis is complete without it, a picture is often invaluable from an anatomical standpoint before surgery of the sinuses, particularly the frontals and sphenoids.

Doctor Ghrist has given us some valuable guides in interpreting the x-ray films, and infers, of course, that the rhinologist should study and attempt to diagnose his own films. This is as it should be, for the clinician has the advantage over the laboratory man in that he can check his findings and interpretations at surgery, and thus improve his diagnostic abilities.

In my opinion, this subject should not be closed without mentioning the value in certain cases of the uses of lipiodol by the Proetz method or by injection, as this may show thickening of the mucous membranes, or polyposes that are not shown by the ordinary methods. Another point that may be spoken of is the value in certain cases of making the exposures while the patient is erect, with the x-ray horizontal to show fluid levels.

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HAROLD A. FLETCHER, M.D. (490 Post Street, San Francisco).—Many roentgenologists are apt to make pathologic diagnoses in reporting their findings from their x-ray examinations. These pathologic diagnoses are often found not to fit in with the clinical picture present. To a physician or a nose specialist who has not taken the time to familiarize himself with reading his own x-ray films, these reports, often accepted verbatim, start the physician and patient off on a completely false path of expensive, painful, and time-consuming treatments and operations. The roentgenologist is still much too anxious to make far too reaching positive diagnoses based solely upon his examination, instead of reporting facts of abnormal changes of density which is all he can accurately do. When he has carefully and accurately recorded his findings, it is quite reasonable for him to suggest the possibilities of the underlying pathology if he knows them.

Many general physicians, general surgeons and (unfortunately, and to their discredit) many rhinologists accept an x-ray report of, for instance, a "cloudy maxillary sinus" and, with hardly a cursory glance at either the x-ray film or the patient, advise a radical antrum operation. This is bad medicine, bad surgery, and certainly suspiciously bad rhinology.

If the various departments of medicine and surgery are going to utilize x-rays in the diagnosis of sinus diseases, they owe it to the patient and to their profession to use them intelligently. Hearing an abnormal chest sound through a stethoscope is not an indication for a rib resection, no matter how remunerative, and similarly it may be said that cloudiness and other x-ray findings in sinus pictures are not of themselves indications for sinus surgery. The abnormal findings by x-ray are sometimes of great help when fitted into their proper place with the other clinical observations. Far too much importance, however, has been attached to these findings alone.

This article is for its purpose quite complete. It points out, in the first place, what one should expect to find in a well-taken film. It points out that, unless a picture is well taken and clear, it is worse than useless to attempt diagnosis from it. It points out the various positions most useful in x-ray studies, and the various findings indicative of pathology, and it finally places the usefulness of x-ray diagnosis in sinus condition in a proper relationship. It is a paper well worthy of careful and intensive study and thought by the general practitioner, surgeon, and rhinologist.

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CHARLES E. FUTCH, M.D. (1930 Wilshire Boulevard, Los Angeles).—The historical and physico-chemical analysis in Doctor Ghrist's paper is of particular interest to the rhinologist, affording him a review which can only result in a better interpretation of his films.

James T. Case said: "It is too much to expect any man to be a specialist in all of the branches of medicine in which roentgenology plays a useful part." This is only too true, but it is entirely essential today that the rhinologist should have a clear understanding of x-rays of sinu-pathology, if he is to diagnose and treat these conditions.

Doctor Ghrist's suggested technique and nomenclature, if generally adopted, would go far toward righting some confusion which still exists in this field and thus assist in what is essential in all scientific work, namely, establishing a common basis of technique for universal study

and comparison. It is hoped that some such standardization will be nationally adopted.

Only emphasis can be laid upon the point already stressed by the author relative to stereoscopic films. Such films are essential to a proper interpretation, particularly in the complex ethmoid labyrinths and sphenoid cells. The remarkable anatomical variation in these cells is well known, and only by stereoscopic view can we expect to interpret pathology. The exactness of knowledge necessary to successful surgery of these regions is greatly fortified by stereoscopic study.

The author correctly states that in the diagnosis of sinus disease an entire reliance upon the x-ray would result in a high percentage of error, but there were certain instances which lack of space and time prevented him from mentioning. Particularly in children where instrumentation, and even a careful examination is difficult or impossible, x-rays are a welcome and very helpful short-cut.

As the x-ray may help, so may it deceive if certain facts are not kept in mind. Proetz and others have carried out experiments showing the extreme deception that may take place in x-rays of allergic membranes. This factor of possible error, namely, the differentiation between true hypertrophy and allergy, must be kept in mind.

Osteomyelitis of the frontal bone presents exceptional difficulty upon occasion, even in stereoscopic films. As stated my Doctor Mosher: "If there is bone necrosis, the bone is infected for an inch to an inch and one-half beyond this area, and the x-ray is not positive until necrosis occurs seven to ten days later," only emphasizing again the point brought out by the author under "osteomyelitis."

RECONSTRUCTION OF THE BREAST*

By HOWARD L. UPDEGRAFF, M.D.
Hollywood

DISCUSSION by William S. Kiskadden, M.D., Los Angeles; Gerald B. O'Connor, M.D., San Francisco; Harry M. Blackfield, M.D., San Francisco.

EVERY surgeon is faced with the necessity of giving advice regarding surgery of the hypertrophied breast. If the hypertrophy is associated with malignancy, we advise radical amputation. If it is a benign overgrowth, what have we to offer the patient?

The past twenty-five years have produced an increasing number of articles on surgery of the benign hypertrophied breast. The great majority of these have come from abroad, while the American literature has been limited to a scant half-dozen. We have copied foreign operative technique, modifying it slightly and accepting its bad as well as good points.

INDICATIONS FOR SURGICAL RECONSTRUCTION

The indications for surgical reconstruction of the nonmalignant breast are necessarily based on such factors as enlargement, difference in size, lumpiness, pain from weight, interference with occupation, and mental instability arising from inferiority complexes due to embarrassment in carrying on ordinary social activities, etc.

Breast surgery should always be authorized by a very definite reason, either physical or mental, or the end-results will not be acceptable to the patient.

* Read before the General Surgery Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

ETIOLOGIC FACTORS IN BREAST HYPERTROPHY

Etiologically there is no generalization which will cover hypertrophy of the breast. One of the most generally accepted causative factors is the wearing of tight brassieres in early life, which cause atrophy of the supporting muscles and suspensory ligaments, with an impairment of the return circulation and consequent fatty deposits. There are also those instances where the body metabolism and the endocrine hook-up is such that there is a localized enlargement of the breast, either *per se* or as a part of the general overgrowth.

DETERMINATION OF BREAST SIZE

The correct size of the breast to be reconstructed is formulated somewhat upon the mental image which comes to the surgeon once the normal nipple locus has been placed. Duerer, in his book on "Human Proportions," in 1528 presented a series of sketches of female figures and their measurements which have been a standard for artists ever since. Granted that the nipple normally is over the fourth inner space, Duerer locates it by dropping lines from the acromioclavicular joint to the umbilicus and places the nipple where this line crosses the fourth inner space. Today the age and wishes of the patient are also important factors.

There has been, as with a number of other newer surgical procedures, a great deal of controversy as to the merits of mastopexy, or breast-shift. The greatest objection to the simple breast-shift has been the possible loss of function, which is not to be dismissed lightly. However, the fact that 80 per cent at least of our hospital postpartum patients are non-nursing mothers, is enlightening. It must be noted in passing that none of the operations described in the literature are dedicated to restoring function. Neither is the average patient seeking breast reconstruction particularly interested in preserving function in an already semi-atrophic breast.

MALIGNANCY AND NON-MALIGNANCY

The question of a differential diagnosis between malignancy and non-malignancy of the breast is one which has been thoroughly discussed in the literature. In passing, however, a recent article by Rodman states that if a patient under thirty-five has a lump in the breast which does not change for two months, he recommends local excision for microscopic study. If over thirty-five and the same situation, amputation is advised; because one-fifth to one-fourth of women over thirty-five, and especially over forty-five, develop carcinoma following chronic cystic mastitis.

Lumps in the breast, however, are mechanical obstructions to breast reconstruction and must be recognized as potentially influencing the character of operation best suited to the patient's condition.

THREE TYPES OF NON-MALIGNANT BREAST

From the surgeon's standpoint there are three types of non-malignant breast in considering reconstruction:

1. The moderately enlarged breast free from lumps that a simple mastopexy, without a lower



Fig. 1.



Fig. 2.



Fig. 3.

Fig. 1.—Hypertrophic nonfunctional breasts. The patient complains of pain and discomfort from weight. Breasts are lumpy and skin is excoriated underneath. Has been advised amputation. Seeks reconstruction if possible.

Fig. 2.—A full thickness graft, including the nipple and surrounding areolar tissue, is transplanted to a point where the normal nipple line crosses the fourth or fifth inner space. The area is prepared by removal of an oval piece of skin slightly smaller than the graft. The graft is anchored in place by a piece of dental wax or stent cut to size. This is held in place by sutures to the surrounding skin for six to eight days.

Fig. 3.—The complete breast content has been amputated and the flap fashioned to form a small nonfunctioning breast. This procedure is recommended only in surgery of the very large lumpy breast where the usual mastopexy or breast shift would be dangerous.

keyhole incision in the skin flap or excision of the gland tissue, will rebuild.

2. The definitely enlarged breast needing a mastopexy, utilizing the keyhole incision and removing varying amounts of breast fat and tissue including an occasional lump.

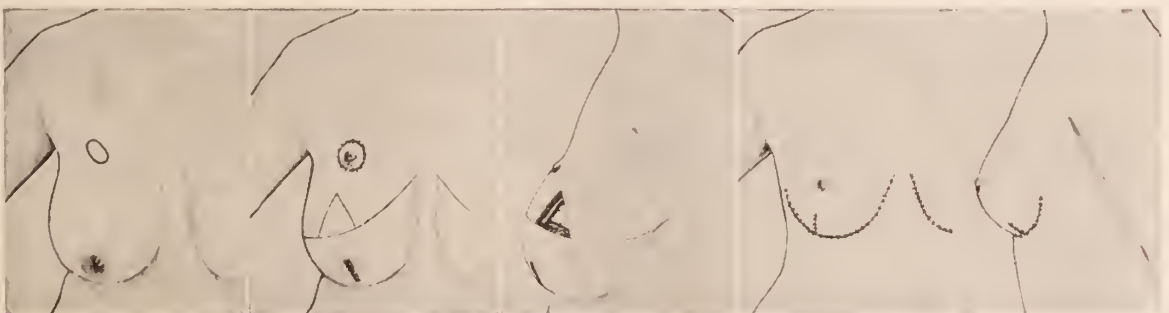
There are many different types of operation for these first two classes of breasts. Each one was very likely devised to fit the type of breast involved, and has to do with the reconstruction of the breast with the nipples left attached. The main differences are in the plan of incision and the procedures to maintain a functional breast. A general surgeon with an accurate knowledge of the blood and nerve supply of the breast, plus an understanding of the planning and handling of skin flaps and grafts with some preoperative meditation and power to visualize final results should be able to perform any of them.

However, the cases must be carefully chosen, as a body metabolism which is markedly off will complicate matters exceedingly. After one has had to care for the various complications following operative work of this type, he becomes very discerning in his acceptance of new cases.

3. The third type is the large nodular hypertrophic breast, which presents marked obstacles in following the surgical plans for reconstruction as applied in the previously mentioned types. These are the breasts usually amputated by the general surgeon. Included in this class is the large breast, which is amputated like the appendix because at times it shows symptoms which do not altogether clear up. For example, the painful lump in the breast occurring each period; also the polycystic fibromas and the breast of chronic cystic mastitis. Added to these are various conditions of the breast, so that when the patient asks of the doctor, "Do you think I should have my breast removed to avoid possible danger in the future?" the doctor is forced to answer, "Yes."

NON-FUNCTIONAL BREAST HERE DISCUSSED

It is the surgery of this type of non-functional breast that I wish particularly to discuss in this paper. A well-planned amputation, carefully performed with a preliminary full thickness nipple graft (Fig. 2), will allow removal of all lumps and the salvaging of sufficient skin and fat to form an acceptable, normal-looking breast.



A

B

C

D

E

Fig. 4.—(A) Area outlined on breast where full thickness nipple graft is to be transplanted. (B) Nipple graft is sutured in place. Defect where nipple was removed is closed in straight line. Breast incision line is marked before operation, with patient standing. Amount of extra angle removed from flap to form breast dependent on size of new breast. (C) Breast flap is cut much thicker than flap for usual breast shift or mastopexy. (D) Flaps are sutured with buried double 00 plain catgut subcutaneously and black silk externally. (E) New "breasts" dressed with parresin-vasclin mesh and stockinette bandages.



Fig. 5

Fig. 6

Fig. 7

Fig. 5.—Young mother who was unable to nurse her baby desires relief from painful heavy breasts, but hesitates to accept radical amputation deformity. Breasts are lumpy and painful, and not good risks for the usual reconstructive technique.

Fig. 6.—Twenty-one days after first stage, with nipple grafts complete take. If portion of graft does not take, additional repair may be made from areolar skin remaining on original site.

Fig. 7.—Eight weeks following first stage. The patient does not wear brassieres and is free from discomfort and pain. These are nonfunctional breasts, but have ordinary skin sensation in both skin and nipple.

Transplantation of the nipple was first reported by Max Thorek in 1922. He did it as an experiment, and was surprised to find that he had a partial take of the graft. Later he reported that, histologically, there was evidence of the nipple surviving. His method at present consists of doing one breast at a time. He reduces the breast to the size he desires, then sutures the nipple where he thinks it should be and dresses it with dry gauze. A week or ten days later he does the other breast. Up to now I have not been able to find any other paper on the subject of free graft of the nipple in American literature.

I can see no objection to this method except that, in placing one nipple at a time, the second breast will differ from the one already done and in the process of healing. Again, when a nipple is transplanted to a flap which has just been raised, one is taking a chance of losing the graft from insufficient blood supply and an inability to apply satisfactory pressure.

OPERATIVE PROCEDURE

My method has been to transplant both nipples at the first stage. This can be done either under local or general anesthesia. The defects left by removal of the nipples are repaired by undercutting, and bringing the circular incisions in the areola together in a straight line. The nipple and areolar skin to be transplanted is denuded of its subcutaneous layer and planted in its new bed over the fourth inner space, from which an oval area of full thickness skin has been removed. The grafts are sutured to the margins and dressed with vaseline gauze, over which a piece of modeled stent is laid. This is held in place by heavy-silk sutures through the graft and skin margins and tied over the stent for seven to ten days. Many patients facing breast amputations are not particularly interested in the preservation of the nipples, provided they can be assured of a semblance of a breast. For these the second stage may be substituted for the first.

The second stage may be performed any time after fifteen to thirty days, as the nipple grafts will have taken by that time. The incision line is marked with the patient standing and the flap made somewhat larger than in an ordinary breast-shift (Fig. 4 c). It is also made as thick as possible, and includes little or none of the breast tissue. This not only grants additional immunity to impaired circulation, but the contraction of the thick flap offers extra material for molding the new breasts (Fig. 4 d). If there is not sufficient material left after amputation of the breast, fat may be taken from the undersurface of the amputated breast and skin, and used as a free-fat graft with surprisingly little absorption.

The breasts are dressed with vaselin gauze and marine-sea sponges, cut so as to aid in forming the breasts and held in place with stockingette bandages. Seven to nine days are sufficient for hospitalization, and ordinary duties may be resumed in two to three weeks. Freedom from brassieres may then be granted and the patient assured of the cessation of her breast worries. There is a tendency for the breast fat to increase somewhat later, giving a more pleasing contour.

The complications of the ordinary breast-shift, namely, hematoma, skin slough, nipple loss, etc., which are more likely to occur in efforts at reconstruction of the third type of hypertrophied breast, are thus avoided. Surrounding skin enervation will give sensation to the nipple in two to four months. Peculiarly enough, the menstrual difficulties usually associated with the hypertrophied breast are greatly relieved.

IN CONCLUSION

In conclusion, I wish to call attention to the thought that if we can offer an acceptable, non-functional cosmetic breast to our patients, who are procrastinating against breast surgery through fear of deformity until too late, then we are contributing another helping hand in the fight on cancer.

6777 Hollywood Boulevard.

DISCUSSION

WILLIAM S. KISKADDEN, M. D. (803 Wilshire Medical Building, Los Angeles).—As brought out by the essayist, the enlarged pendulous breast can be reconstructed both functionally and cosmetically by a variety of procedures. The greatly enlarged pendulous and nodular breast, however, because of its very size responds less well to the usual operative process. This method of transplanting the nipples will give a cosmetic result quite superior to partial amputation. Whether the loss, or at least diminution of nerve supply, the danger of nipple necrosis, the definite division into two operative procedures, when transplanting the nipple, is wiser than perhaps a fair cosmetic result from one of the other methods of treatment, is a question to be answered by the individual surgeon. Certainly, when amputation of the entire glandular breast tissue is considered, this procedure will give a much better cosmetic result. The author deserves credit in helping to pioneer an operation which, on first thought, would seem to be fraught with considerable uncertainty. It is a procedure which has a limited but definite place in the reconstructive surgery of the breast.

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GERALD B. O'CONNOR, M. D. (490 Post Street, San Francisco).—Reconstruction of the idiopathic, hypertrophied breast has become an accepted rational surgical procedure to bring relief to those persons so afflicted, whether from a symptomatic or mental point of view. This work has been brought about over a period of years by enlightening contributions, both foreign and American, of men interested in the physiologic reconstruction of enlarged mammary glands. In the enlarged functioning breasts, proper surgical reconstruction will not interfere with breast function in the majority of cases.

Doctor Updegraff's method, of the primary free transplantation of the nipples, is a contribution to the type of breast surgery as reported by Max Thorek in 1922. His points of delayed healing and, more likely of nipple necrosis when following the Thorek technique, are well taken, and his sequence of nipple transplantation certainly diminishes these possibilities. The proper location of the new nipple is a difficult task, in spite of preoperative planning, and a full allowance should be made for the redisturbance of chest skin following undermining and elevation for the newly constructed breast.

I wish to emphasize the fact that the free transplantation of the nipple is a Wolfe graft, and that this type of graft, even in the most experienced hands and under ideal conditions, is very uncertain as to complete take, so that any surgeon contemplating Wolfe grafts of the nipple should warn the patient as to the possibility of partial or complete loss of one or both nipples. Free transplantation of the nipples should rarely be done, and I am in accord with the views of the author that it should be reserved for those large, nonmalignant nodular breasts for which amputation has been advised.

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HARRY M. BLACKFIELD, M. D. (350 Post Street, San Francisco).—The author has briefly but excellently reviewed our present ideas on the subject of breast hypertrophy. His paper again emphasizes the fact that reconstruction surgeons must be well-grounded in the field of general surgery, as well as in plastic surgery.

The recommendation, that one should think of breast reconstruction when considering amputation of the breast for a nonmalignant condition, is to be commended. This holds true particularly for young women. Inasmuch as two operative procedures are required for breast reconstruction, as against one when simple amputation is done, the patient should be allowed to make her choice.

A word of warning, however, should be given about the use of free full thickness or Wolfe grafts. Even men who have had a great deal of experience and success with this type of graft occasionally have failures, and the novice will find that his percentage of successful takes will be very low.

THE FEET IN YOUNG CHILDHOOD: SOME FACTS AND FALLACIES*

By EDWIN F. PATTON, M.D.

Los Angeles

DISCUSSION by Clifford Sweet, M. D., Oakland; Maynard Harding, M. D., San Diego; E. Earl Moody, M. D., Los Angeles.

SEVERAL conditions of childhood, including rachitic deformities, faulty posture, Frölich's knock-knee, epiphyseal disorders and minor foot defects, fall into the fields of both pediatrics and orthopedics, yet belong strictly to neither.

Since most orthopedic men are primarily mechanical-minded, and are not fully appreciative of such pediatric considerations as constitutional type, nutritional state, and physiologic efficiency; and since most pediatricians involuntarily shudder at the thought of mechanical appliances, these conditions have come to occupy the position of medical stepchildren, and consequently are bound to suffer some neglect when managed by one or the other specialty alone.

Minor foot defects probably suffer most, since reciprocal reference of such cases is hardly felt worth the cost. Yet, because of this, their management has become slipshod, both orthopedic men and pediatricians having rather unthinkingly allowed themselves to pick up and adopt certain fallacious conceptions regarding them.

NO EMPIRIC STANDARD OF FOOT CONFORMATION AND DEVELOPMENT

Fallacy number one is that there is such a thing as an ideal standard of foot conformation and development by which all feet should be judged. This is just as untrue as that the standard weight-height-age tables apply unequivocally to all individuals. Actually, there is as much variation in normal feet as there is in normal noses. Frequent repetition has factualized in most of our minds such statements as these: that longitudinal arches should be established when walking commences, and that the transverse arch should develop soon after walking begins; that the normal foot has a straight inner border, an appreciable arch and a straight heel-cord when the weight is put upon it; that there should be a vacant space in the foot-print under the three inner metatarsal shafts, scaphoid, and the forepart of the calcaneus; that if all these criteria are not met the foot is not normal. I cannot subscribe to these statements since, in fifteen years of observation in pediatric and orthopedic clinics and school systems, I have seen feet exhibiting wide variations from these standards which, from the standpoint of function, were all that could reasonably be desired.

Feet are part of the body as a whole, partaking of the characteristics of the rest of the body make-up. They vary with hereditary or constitutional body type, embryonic defects, developmental factors, vagaries of physiology, nutritional situations, general tissue tone, general and local state of

* Read before the Pediatric Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

health or disease. They must be judged in relation to all of these considerations, plus, most important of all, how well they serve their owner. Conformation is not the whole answer by a great deal. In many instances feet which are functionally highly efficient would not satisfy artistic criteria of form. In many other instances well-formed feet are unduly fatiguable, awkward, or painful on use.

In pediatrics there is frequently encountered a type of child which I think is best described as hyperelastic, in whom the weight-carrying structures are of perfect strength and tone, but stretch out more under stress than the average. These youngsters are endowed with hyperextensible joints; even after walking begins, it may be possible to bring the dorsa of their feet almost up against their shins. When their feet are allowed to dangle they rest in perfect position, but when the child steps on them, naturally they pronate and the forefoot goes into eversion.

Carpal development and blood chemistry are normal. General health and development are perfect. How can this then be considered an abnormal condition requiring cumbersome appliances for correction? In my opinion these children should be given the test of time, and in almost all instances after a few months or years nature will diminish the excess elasticity to the point where arches will remain perfect when body weight is applied. Of course, if awkwardness, fatiguability, or pain on use develops in this kind of case, that is a signal for support. My answer to the contour fallacy, then, is that while efficiency and generally accepted standards of contour usually do go together, they are not invariably parallel; and the answer to the time-of-arch development fallacy is that it varies within extremely wide limits and that it is not nearly so important, anyway, as is the relationship between development of functional capacity consistent with the increasing burden as growth in size and weight takes place.

STIFF SHOES ARE NOT NECESSARY

Fallacy number two is that babies need stiff shoes to help them learn to walk. The truth of this is that babies learn to walk at a time and at a rate determined by their neuromuscular development, and shoes have very little to do with it. For the perfectly normal foot, shoes are not necessary at all, and if worn should be regarded as merely gloves for the feet, to protect against cold and injury. If walking is delayed by abnormally weak feet, it will take more than the mere ankle-stiffening provided by shoes to enable the child to catch up.

CORRECTION OF PRONATED FEET

Fallacy number three is that all pronated feet need to be corrected. In the light of instances already given, I feel that this must be qualified to read: If pronation is accompanied by awkwardness, undue fatiguability or pain on use to such an extent that potential efficiency is cut down, then artificial aid is indicated. Otherwise, time is the only appliance that is reasonable to use.

RELAXED ARCHES

Fallacy number four is that all relaxed arches require correction. The answer is identical to that given for pronation, namely, the imperative rests on the disabling accompaniments of relaxation—not on the relaxation itself.

SHOE-HEEL FALLACY

Fallacy number five is that pronation can be corrected by tilting up the inner border of the shoe-heels. This may suffice for a few days in new shoes, but after this short time the leather gives and the heel rotates around into its former bad position. Without accompanying support under the scaphoid bone to hold up the arch which always goes down when the foot pronates, tilts are about as good as useless.

CORRECTION OF FLAT FEET

Fallacy number six is that flat-foot can be corrected by wearing commercial orthopedic shoes. There is no orthopedic shoe on the market which carries full arch correction. The features usually present in these shoes are: straight inner border, roomy toe, steel shank, advanced inner counter, advanced elevated inner border of heels, all on a basis of extrasubstantial construction. The final result is about half of the amount of arch correction that is needed. Too many pediatricians, and even orthopedic men, consider it enough to send their patients with pronation or arch depression to some shoe clerk with whom they are particularly friendly, carrying an order to fit suitable shoes. This is a halfway measure analogous to sending a child with a severe refractive defect to an optometrist. If a foot really needs an arch support, nothing short of a made-to-measure semi-rigid arch plate fitted inside of shoes which will hold the foot in place on the plate will suffice. The best arch supports for all ages are those of metal, the size and weight being regulated to the individual. No other material has the permanence, the physiologically favorable amount of springiness and the adaptability of metal.

ARCH PLATES

Fallacy number seven is that all cases of flat-foot will be corrected by arch plates and suitable shoes. Flat feet secondary to malnutrition, anemia, chronic devitalizing disease or devitalization by acute disease, will not respond until the basic cause is corrected, and general good health restored. Acute foot collapse of puberty will not be overcome by mechanical means until endocrine readjustment has taken place either spontaneously or with medical assistance. There are certain congenital flat feet which nothing short of operation will influence.

FOOT EXERCISES

Fallacy number eight is that flat-foot can be corrected by exercises. Muscle-pull is a very minor element in arch maintenance. Exercising the inverters of the foot ten or *fifteen minutes* a day can have but little, if any, influence on what they will do during the *twelve* or so weight-bearing

hours of the day. Besides, if these muscles are atonic, it is usually because the entire muscular system is atonic as a result of one of the conditions just mentioned. The logical approach, then, is by way of improvement of general condition. While the customary exercises can do no harm, probably much more would be gained by rest and medical care. A few years ago, in an extensive survey of Los Angeles school children whose flat feet and bad posture did not respond to corrective physical education, I very quickly found the reason. Practically all of these children were malnourished, subvital and chronically fatigued. The money spent maintaining an expensive school department could have been applied to much better purpose in giving these children good food, adequate vitamins, rest, sunshine, and fresh air. Under such a regimen their arches and backs could not have shown less improvement, and I confidently believe would have shown a great deal more.

EARLY WALKING

Fallacy number nine is that flat-foot is caused by too early walking. Walking seldom begins till bones, ligaments, and muscles are ready; nature sees to that by not providing the impulse before. If structures are not of proper tone, precocious walking practically never takes place. When walking does start, if structures are normal, they will hold up. If they are not adequate they will go down no matter to what age weight bearing is delayed. The fault is with the structures and not with their use, and restricting walking will make no difference unless structural condition is naturally or artificially improved in the meantime.

SHOE WEDGES

Fallacy number ten is that a wedge under the inner edge of the foot will correct bow-leg or knock-knee. If a bow-legged or knock-kneed child has, in addition, feet which need support, supports should be provided for the sake of the feet themselves and not to influence the legs. It is inconsistent to ask Wolfe's law of "growth in the direction of weight-bearing line" to work the miracle of correcting opposite deviations by identical adjustments. Bones grow crooked or straight because of the internal factors of calcium phosphorus metabolism and neurotrophic guidance, unless a strong external influence is applied; and this influence must be far more powerful than a simple shoe tilt. If knock-knees or bow-legs do not improve, or grow worse, under medical treatment, then nothing short of braces will get the desired results. It must be remembered that most infant legs are normally bowed, and most run-about legs go through a normal knock-knee phase. Both of these correct themselves unless there is some definite underlying defect present.

HIGH HEELS

Fallacy number eleven is that high heels should never be worn. Young girls who have been troubled for years with minor arch depression frequently become trouble-free when they reach the high-heel age. High-heeled shoes have per-

force a high built-in arch, higher in fact than most arch supports; and unless the foot is too badly relaxed they often give that little added support which is all the foot needs to assume good position and function. Of course, sharp, narrow toes, such as many high-heeled shoes have, are vicious, but the heels themselves need not be absolutely condemned.

SUMMARY: MINOR FOOT DEFECTS

To sum up minor foot defects, then, we find that the primary essential in appraisal is to apply a criterion of reasonable functional efficiency in relationship to the child as a whole; and the primary essential of treatment is to bring general condition to par. The secondary essential of treatment follows, namely, *complete* and not *halfway* measures of mechanical positioning. A practical working foot, not a visionary ideal, should be our goal.

MAJOR FOOT DEFECTS

Of the major foot defects, the one that concerns the pediatrician most, is perhaps Köhler's scaphoiditis, which is now considered to be a partial death of the scaphoid bone from ischemia, usually precipitated by trauma, but occurring on a basis of poor calcium-phosphorus metabolism. It is as essential for the child with this disease to have nutritional guidance and possibly endocrine work as to have orthopedic care.

Next in pediatric interest would come perhaps the chronic sprain of the calcaneal apophysis frequently seen just prior to puberty, to which the last statement is equally applicable.

When feet are encountered which have bony knobs or prominences, especially at the scaphoid, the rule is that if they give sufficient mechanical trouble by rubbing and bursa formation, the prominences have to be removed surgically.

There is a problem foot known as the metatarsus primus varus foot in which the first metatarsal is set with its base more laterally and its head fanning out more medially than usual, with pronation as an almost invariable accompaniment. The bad part about this foot is that the great toe is thrown medially where it encounters shoe pressure which predisposes to hallux valgus. Pronation of the foot decreases the fanning of the first metatarsal and thus lessens the tendency to hallux valgus. Overcoming the pronation increases both of these. The question here is of major orthopedic importance involving a decision as to which is worse, pronation or hallux valgus. The only way around it is by open osteotomy in the proximal third of the metatarsal with suitable realignment of the distal portion.

As regards other major defects it is essential for the pediatrician to be able to recognize them, to know that the earlier treatment is instituted the better the results, and to know also that treatment must continue until growth is complete because the influences which cause such conditions in the first place persist indefinitely. This last statement is particularly true of club-foot, and because of tendency to relapse after correction I have devised a celluloid maintenance slipper which can

be worn inside of an ordinary shoe. When the weight is put down in this device the foot is forced into slight overcorrection. Celluloid does not give way, a characteristic which overcomes the drawback of leather which after a short period warps with the warmth, moisture, and pressure of the foot and allows the deformity to recur.

Congenital claw-foot is probably, like club-foot, a result of neuromuscular deficiency allowing heel and forefoot to drop down and the plantar ligament to shorten. Because of the short lever arms involved, surgery such as plantar fasciotomy and tarsal stabilization is often necessary.

A well-developed hallux valgus usually requires surgical reconstruction of the first metatarsophalangeal joint even in childhood.

The foot of cerebral palsy is a complicated problem, the objectives being: by surgery or braces to bring the foot into a neutral walking position and to hold it as steady as possible in this position. Tendon lengthenings and stabilizations are frequently necessary.

In poliomyelitis each foot is an individual proposition in which the material at hand is appraised and is rearranged to bring about maximum functional adequacy. Lateral stabilization is the most frequently helpful measure. Tendons may be transplanted, but too much reliance should not be placed on this measure since the power and the performance of transplanted muscles are unpredictable, and what may result after a period of years may turn out to be a new defect in itself.

IN CONCLUSION

To conclude, then: for defective young feet to receive optimal care it will be necessary for orthopedic men and pediatricians to train themselves in each other's specialties or else to cooperate more than they do at present.

3875 Wilshire Boulevard.

DISCUSSION

CLIFFORD SWEET, M. D. (242 Moss Avenue, Oakland). Doctor Patton has presented a matter that has a very important place in child welfare.

I cannot agree, however, that "most orthopedic men are mechanically minded." On the contrary, I have found among them a very real appreciation of "constitutional type, nutritional state, and physiologic efficiency." They probably differ from pediatricians, more generally, in point of view because by far the greater number of their patients come to them, either because they have the more extreme mechanical faults or because physiologic efficiency has fallen to the stage of painful symptoms, and they may, therefore, demand mechanical or surgical treatment. The pediatrician more generally sees the patients with minor defects, or with the more serious defects, while preventive measures may still be effective. Also while the orthopedist has generally more special knowledge concerning body mechanics, the pediatricist has the great advantage of studying many children while they pass their successive stages of development.

I agree entirely that feet should not be judged solely on their form and, especially, that too much attention should not be paid to the height of the longitudinal arch. I am reminded of the West Virginia recruit, a barefooted and, therefore, flat-footed mountaineer, who, having been rejected for military duty because of flat feet, remarked: "Well, I'll have to walk that five hundred miles back home again."

I commend to all who care for children Doctor Patton's thought, "Feet are part of the body as a whole," and that

rest and improvement of the child's general health are fundamental if any other measures are to be carried to a satisfactory degree of success. He has not mentioned, however, that the feet are not only a part of the physical make-up of the individual, but are also only one group of the mutually interacting muscles, tendons and joints which enter into and determine the efficiency of the patient's entire system of body mechanics. For example, unbalanced feet (pronated and everted) are only one part of a Class C posture with its forward thrust head and shoulder girdle, weak abdominal muscles, lumbar lordosis, anterior rotation of the pelvis, internal rotation of the thighs, external rotation of the legs and either marked shortness of the posterior calf muscles and tendons, with a resultant pull that forces and holds the foot in eversion and pronation, or abnormally long posterior calf muscles (the hyperelastic child), which do not support the foot sufficiently to prevent marked pronation. While it is true that correction of the feet has, no doubt, some favorable effect upon the entire mechanics of the body, the part played by this correction alone must remain a small one. The faulty mechanics of the entire body is the cause, and the malposition of the feet only one of many effects. A child may have perfectly corrected feet and maintain a Class C posture, but correction of the posture to Class A, or even B, is impossible without simultaneous, marked improvement in both the weight-bearing position of the feet and their function in locomotion.

Stiff shoes are not necessary, and actually impede the child's progress, from the infantile stance in which stability, while standing, is the only objective, and forward movement is accomplished by shifting the weight alternately from one foot to the other, while the center of gravity is moved forward in a plane parallel to the ground; to the more advantageous method which comes with better coordination, enabling the child to reach forward with the foot to grip a new point of leverage and propel the center of gravity forward much more rapidly and effectively in a succession of connecting upright arcs. Reasonably stiff-soled shoes, with a heel one-half inch or more in height attached, are very useful in assisting the child who walks late and badly because he has abnormally long posterior calf muscles. This simple appliance will allow the abnormally long muscles to shorten and will spare the feet, usually congenitally weak, from the undesirable changes that follow prolonged use in the weak, pronated position.

All babies are bow-legged, and the legs straighten with walking. All children become knock-kneed and have pronated feet, reaching the height of this stage in normal development at three years of age. At the age of five, six and, at the latest, seven years of age, the knock-knee will have disappeared and pronation will have largely righted itself. We may be doing harm (at least making parents unnecessary expense) and we are certainly doing no lasting good when we interfere, except in pathologic states, with any condition which is a part of the normal growth and development of children.

✽

MAYNARD HARDING, M.D. (700 Electric Building, San Diego).—Discussion of Doctor Patton's paper within the limits of space available is not possible. Speaking from the standpoint of an orthopedic surgeon, I would say that the essayist has set up a row of straw men to knock over for the purpose of emphasizing his very common-sense conclusions. Certainly, his so-called fallacies are not believed by my confrères, to my knowledge.

The important thing stressed by his conclusion is cooperation of the pediatricist and orthopedist for mutual benefit and broadening.

✽

E. EARL MOODY, M. D. (3780 Wilshire Boulevard, Los Angeles).—Because Doctor Patton has listed as "fallacies" so many of our simple procedures for the correction of minor difficulties of the feet of children, he has left us with few "facts." I agree with him, however, when he states that there is no ideal standard of foot conformation. This viewpoint will save us from a dilemma, similar to that which overwhelmed us in the old days, when we rigidly adhered to the height-weight tables to measure nutrition in children.

I would emphasize his observation that the general nutritional picture of the child has much to do with efficiency in function of the feet. General strength and good vitality usually make certain such qualities in the feet. I am glad to see him emphasize the fact that shoes are worn as gloves for the normal feet. The most flexible shoe possible is ideal for the normal foot of the rapidly developing child.

Do not, however, some of Doctor Patton's ideas smack somewhat of nihilism? If heel-lifts, orthopedic shoes, and exercises do little or no good, then it seems that we are left with very little to do for these minor difficulties, except to correct the general nutrition of the child. I believe we would be amiss if these simple, and at least harmless, procedures were omitted in indicated cases. Perhaps the child would grow out of such minor difficulties as pronated and flat feet and knock-knees if we did nothing. However, if we failed to use these corrections, the blame would be ours should the child not make these adjustments. I have seen too many children rapidly and permanently improve when these simple, indicated corrections were made, to be willing to call them fallacies. I believe them to be too valuable as aids in the problem of nutrition and development to discard them.

✱

DOCTOR PATTON (Closing).—Doctor Sweet's discussion adds significant things which time would not allow in the original.

Doctor Harding—and San Diego—are to be congratulated if their community does not face, as does Los Angeles particularly, the widespread influence of confrères and lay bodies whose ideas are in accord with the fallacies which he so euphemistically terms "straw men."

Doctor Moody is not disagreeing, because there cannot be any possible objection to utilization of the simple measures he mentions; especially if—as I am sure is automatic in Doctor Moody's practice—the proper medical care is given at the same time.

PERIPHERAL ARTERIES: THEIR IMPORTANCE IN INDUSTRIAL PRACTICE *

By FELIX PEARL, M.D.
San Francisco

DISCUSSION by *Vernon P. Thompson, M.D., Los Angeles; Emile Holman, M.D., San Francisco; William J. Kerr, M.D., San Francisco.*

DURING the past few years the attention of the profession has been focussed, more than ever before, on the necessity for a clearer conception of the nature and course of affections of the peripheral arteries. The resultant investigations have borne fruit, so that at the present time the diagnosis and treatment of these affections rests upon a firmer and more accurate basis than was ever dreamed of previously.

There is no doubt that many insurance companies are being heavily taxed by the financial burden of patients who are suffering from manifest or occult chronic arterial disease, and that many of these patients are losing the benefit which early diagnosis and rational treatment offer them, not only for the present, but for the future as well.

In discussing the rôle of the peripheral arteries as related to industrial practice, one may divide the subject into two broad phases: (1) Direct injuries to previously normal peripheral arteries, and (2) industrial accidents occurring in individuals who have chronic arterial disease.

INDICATIONS AND TREATMENT

Contusions and lacerations of large arteries are the most common direct injuries. If the main artery to an extremity is completely severed, the vessel should be immediately sutured if it is possible to approximate the ends. If it is cut two-thirds through, it should be converted into a complete section. The Carrell technique is used in our department of sympathetic and vascular surgery. Only three weeks ago, the writer successfully performed circular arteriorrhaphy of a severed brachial artery in a child of nine years. If suture is impracticable, it may be necessary to transplant a section of vein or to ligate the artery. For arterial ligation silk or tape is recommended, which is about one-fourth the diameter of the vessel to be ligated. According to the "Golden Rule" of Matas, the artery should be ligated directly at the bleeding point rather than in continuity at a distance from the injured site. I follow the practice of anchoring the main ligature by a mattress suture of fine silk, which passes through all the coats of both walls of the artery and embraces the ligature. This prevents the ligature from blowing off. Whenever the main artery to a normal extremity must be ligated, the question arises as to the desirability of ligating the main vein at a higher level. This should be determined in the individual case at the time of operation, utilizing the response to the Henle-Coenen and the Von Frisch tests for the competency of the collateral circulation, rather than by any set rule to ligate or not to ligate in every instance. To secure permanent ligation the vessel should always be transected between ligatures, and the cut end separated. When the artery is cut, one obtains the same effect as by periarterial sympathectomy in temporarily eliminating vascular spasm, which is often a factor of tremendous importance in the clinical picture of ischemia. The use of suction pressure therapy in cases which show evidence of dangerous vascular insufficiency may also be considered. Acute traumatic thrombosis of the main artery is a difficult problem. Here, opening the artery and attempting to remove the thrombus are at times indicated if tissue death is apt to ensue. At operation periarterial sympathectomy should be performed above the site of thrombosis to eliminate vascular spasm for a period of several weeks, during which time a competent circulation may have developed. At the same time, if it is considered wise, the main vein may be divided proximal to the site of arterial injury.

Large arteries may be eroded by processes secondary to trauma, which attack the wall from without, such as abscesses, cellulitis, and thrombophlebitis. Recently, a patient was referred who had had an extensive traumatic thrombophlebitis of the inner aspect of the right thigh, complicated by multiple pulmonary infarcts and followed by a sudden hemorrhage from an eroded femoral artery. The surgeon in charge acted promptly, and ligated in continuity the femoral artery above the site of erosion. At the present time, fifteen months after ligation, the dorsalis pedis pulsation is just felt, the extremity is warm and well nourished,

* From the Clinic of Sympathetic and Vascular Surgery, Mount Zion Hospital.

Read before the Industrial Medicine Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

and vasomotor studies show a normal vasodilatation level. He has symptoms due to spasm of the arteries of this extremity brought on by exercise, which prevents him from working. These symptoms are not produced during the time that the homolateral lumbar sympathetic chain is blocked with novocain. I have advised lumbar ganglionectomy to relieve this disabling arteriospasm. Abnormal arteriovenous communications may occur from puncture wounds which injure simultaneously the vein and adjacent artery. These interfere with the competency of circulation of the extremity and throw a severe load on the heart. The collateral circulation which results from arteriovenous aneurysm is tremendous, and there is little danger in attacking these surgically if one waits from four to six months. The ideal treatment is ligation of all the vessels, arterial and venous, which open into the sac, and removal of the aneurysm under scrupulous asepsis. This differs from the treatment of traumatic aneurysms in which the sac should be preserved to keep valuable collateral vessels intact.

We now come to the consideration of the patient with chronic arterial disease. The usual type of history and the methods of study are exemplified by the following case reports.

REPORT OF CASES

CASE 1.—A man of forty-four years was referred by one of the major insurance companies for special examination, to determine whether arterial disease was a factor in a long-continued disability. He had no symptoms until August 23, 1933, when, while employed as a tractor operator, the ends of the fingers of the right hand were struck by the steering lever. Many of the details of the history were elicited only after careful questioning at the time of special examination. A few days later, small gangrenous spots appeared on the tips of the index and ring fingers, and finally sloughed in about three weeks. The right middle finger became bluish, swollen and exquisitely tender, so that on September 9, 1933, he was forced to discontinue his employment. On September 20, 1933, "pus" accumulated under the nail and the nail was removed. The entire nail bed then became gangrenous, separating about a month later. X-rays showed a fracture of the terminal phalanx. Healing was so delayed that the terminal phalanx was amputated, and after the stitches were removed the wound edges separated and became infected. On March 8, 1934, the wound was healed, but opened again soon afterward, extruding sequestra and forming small abscesses followed by sinuses. This never again healed, and on August 21, 1934, amputation was done at the proximal interphalangeal joint.

About March 14, 1934, he was attempting to turn a valve when he felt a sharp pain in the index and middle fingers of the left hand. There was no direct injury. In the latter part of April, gangrenous spots appeared on the tips of these fingers, the slough separated, leaving discharging ulcers which did not heal until June 27, 1934. A few weeks later pus accumulated under the nail of the left index finger and the nail was removed. The nail bed became gangrenous, and sloughed in about two weeks, exposing the bone. The bone is still exposed. His left index and middle fingers became cold and cyanotic in cold weather.

On examination it was found that the right radial and brachial pulses were diminished. Both hands blanched on elevation and became ruboric on dependency. The hands were exposed for thirty minutes to a constant room temperature of 16.7 degrees centigrade. The right hand was very cold to the wrist by actual measurement with the dermaterm. There was a diffuse blotchy cyanosis involving the entire hand, worse on the right index finger, which was almost purple. The picture suggested vasospasm. The

scars of the previous ulcers were visible. The sutures were still in place from the recent amputation at the proximal interphalangeal joint of the middle finger. The left hand also showed a blotchy cyanosis of the entire hand; especially marked on the index and middle fingers. The hand was cold, but about 2 degrees centigrade warmer than the right. On the tip of the left index finger was an ulcer of its dorsal surface, exposing about one centimeter of the bone of the terminal phalanx. The bone was dark and necrotic. The picture was typical of arterial disease.

The next point in the investigation was to determine whether the evident arterial disease was due to spasm or occlusion. Both hands were exposed to a room temperature of 15.6 degrees centigrade for thirty minutes, and the surface temperatures measured. The left inferior cervical, first and second thoracic sympathetic ganglia were then suffused with novocain by the posterior route. Although complete sympathetic ablation was shown by a typical Horner's syndrome and anhidrosis of the left upper extremity, there was no rise in surface temperature of the digits or change in color. A similar procedure was carried out on the right without effect. This indicated occlusion without spasm. The clinical picture, however, was so suggestive of spasm that it was thought best to check the results. The right ulnar nerve was blocked at the elbow. There was anesthesia in the ulnar distribution, but very little rise in surface temperature of the little finger, although the hypothenar eminence reached almost the normal vasodilatation level. These studies showed that the arterial disease was occlusive in nature and had only a slight element of spasm.

The feet showed absent dorsalis pedis pulsations with blotchy cyanosis similar to that seen in the hands. On the basis of the history and special studies, the diagnosis was made of chronic obliterating arterial disease of all four extremities, worse in the upper extremities; probably thromboangiitis obliterans. The underlying pathology was, of course, not compensable.

COMMENT

It is surprising that with such a typical history and objective findings during an entire year of treatment by good industrial surgeons, arterial disease was not suspected until his last amputation. The realization that severe chronic occlusive arterial disease has been the dominant underlying factor in his disability, and that the outlook is for progression of the disease, is of great significance in the further handling of this case.

CASE 2.—Another male, age thirty years, was employed in making and bottling preserves. He claimed that his feet and hands were wet almost constantly from the drainage which, he stated, contained acid used in the preservation of the fruit. In about May, 1935, a crack appeared in the tissues of the right heel, which became painful and ulcerated. About four weeks later the right second toe became painful, and within three weeks of the time had become gangrenous. He was treated with suction pressure therapy from July 17, 1935, until August 7, 1935. On September 19, 1935, this toe was amputated. In spite of the continuation of suction pressure therapy, marked swelling appeared on all the toes of the right foot, extending to the ankle, and gangrene appeared in all the toes. There were never any symptoms on the left. He smoked twenty cigarettes daily. On investigating his past history, it was found that in 1929 a small receptacle struck his right great toe, giving him little or no pain. That evening the toe became red and two days later a blister formed, which developed into a discharging ulcer. A few days later the adjacent toe passed through a similar train of events. It took four months for these lesions to heal, and for one year afterward the right great toe became painful in cold weather. This patient presented a claim to the Industrial Accident Commission that his present condition was directly due to his employment and, therefore, compensable.

On examination the upper extremities were normal. The right lower extremity showed a dry gangrenous

process involving all the toes, and extended about one and one-half centimeters on the dorsum of the foot. There was a small ulcer on the inner aspect of the heel about one-half centimeter in diameter. The foot was markedly swollen to the ankle. No foot pulsations were felt. The popliteal pulsation was diminished. There was mild ischemia on elevation and mild rubor on dependency. On the left lower extremity the dorsalis pedis pulsation was diminished, otherwise the vessels were normal. The clinical picture was quite typical of an obliterating arterial disease, involving both lower extremities, especially the right. The further course of the disease confirmed this. About ten days after this examination the lower extremity was amputated at the junction of the upper and middle third of the leg, and pathologic examination showed a severe thromboangiitis obliterans. In the testimony before the Industrial Accident Commission it was shown that the discharges contained no irritating substances which could have been the factor in producing the original ulcer, and that his disability was the end-result of the progress of an underlying chronic arterial disease which had been present for several years, and which had no causal relationship to his employment.

COMMENT

Whenever there is delayed healing of wounds without apparent cause, a history of chronic ulceration or gangrene, or symptoms of arterial insufficiency, and especially when these are associated with objective signs of arterial disease, the patient should be given a complete vascular examination. By this is meant a careful clinical investigation, a carefully controlled test of the part played by the sympathetic nervous system, and tests for the state of collateral circulation of the skin, if indicated. Diminution of arterial pulsations, decrease in local temperatures, ischemia on elevation, rubor on dependency, trophic changes, discoloration, ulceration and gangrene, all give objective evidence of failing circulation. The surface temperature of the part is in direct proportion to the amount of blood flowing through it. By measuring the skin temperature, under controlled conditions, before and after paralysis of the vasoconstrictor fibers, one can determine whether the failure of the circulation is due to arterial occlusion, to pure arteriospasm, or to a combination of both. In the latter instance, one can determine quantitatively the relative proportion of each. Vasoconstrictor paralysis may be induced by various means. We prefer novocain block of the peripheral nerves, using the posterior tibial nerve for the feet, and the ulnar or median nerve for the hands. Whenever there is a question of the reference of pain over sympathetic pathways, the lumbar chain should be blocked directly.

In patients with occlusive arterial disease, the state of the collateral circulation of the skin may be estimated by the local response to intradermal injections of histamin. The lack of appearance of a flare indicates a poor collateral circulation, and warns against the use of such areas as covers for amputation stumps.

If arterial insufficiency is purely or predominantly spastic, the treatment is directed to ablation of sympathetic influence. Conservative measures are tried first, and if no relief is afforded, sympathetic ganglionectomy is to be considered. If the disease is predominantly occlusive, sympathectomy will give little relief.

Certain selected cases of occlusive disease are benefited markedly by ligation of the main vein

to the limb. Our experiences with a small series of cases has been gratifying.

It is felt that suction pressure therapy will have a definite place in the treatment of these cases, but one should be guarded in his prognosis of results until experience with this method becomes more general. In our sympathetic and vascular department, the results of suction pressure therapy have been somewhat disappointing.

IN CONCLUSION

It is hoped that the more general realization of the important part played by diseases of the peripheral arteries in many industrial injuries will lead to a greater coöperation between the industrial and the vascular surgeon, to the benefit of both the patient and the insurance carrier.

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DISCUSSION

VERNON P. THOMPSON, M. D. (2007 Wilshire Boulevard, Los Angeles).—The first portion of Doctor Pearl's paper gives an excellent summary of the surgery of direct injuries to normal peripheral arteries. My discussion will be confined to the second phase of the paper—that of industrial accidents to individuals with preëxisting chronic arterial disease. It would be difficult to compile from any series of cases two more informative than he reports.

The rôle of industrial accidents in precipitating or aggravating symptoms, due primarily to preëxisting occlusive arterial disease, cannot be appreciated except on a basis of thorough clinical study of the circulatory phenomena present. Simple, direct, clinical observations are sufficient in the great majority of cases to establish the adequacy or inadequacy of the circulation.

Can the muscles do a reasonable amount of work without complaints or cramping? If so, the volume flow of blood through them is adequate. Are the feet and lower legs warm, capillary beds pink, the color remaining on elevation, returning quickly after pressure? If so, further encouraging information is obtained. Is the skin elastic, firm, and not atrophic, inelastic, or doughy and edematous? If, on the contrary, impairment of muscular activity, presence of blanching of capillary beds on elevation, poor nutrition of the skin, and muscular atrophy with persistent coolness are present, there is direct evidence of an inadequate blood volume flow to the extremities.

Data as to the various arterial pulsations present or absent, of calcifying changes in the x-rays, are obvious observations to make and record, but do not bear directly on the question of adequacy or inadequacy of the actual capillary blood volume flow. While detailing the more elaborate tests of determining blood flow, whether due to fixed occlusive processes, or due in part to vasospasm, Doctor Pearl has wisely emphasized the easily obtained clinical data which should shorten the waiting period of months, even years, between the onset of symptoms and the diagnosis.



EMILE HOLMAN, M. D. (Stanford University Hospital, San Francisco).—Experiences such as are recorded in Doctor Pearl's article, illustrate the necessity of careful physical examination of all applicants for positions in industry. Such physical examinations should consider not only the state of the heart and lungs, and the presence or absence of hernia, but most particularly the state of the peripheral vascular system. Absent pulsation in the dorsalis pedis and posterior tibial arteries need not necessarily preclude employment, but a record of an inadequate circulation would be of great help in case of subsequent injury. Moreover, even though symptoms are not present at the time, much can be done to avoid trouble if, in the presence of absent pulsation of peripheral arteries, certain instructions are given to the applicant. He should be warned against injury by ill-fitting shoes, by cutting corns and nails, and by frostbite. If injury does occur, precautions against infection should be carried out immediately: (1) by washing with soap and water; (2) by the application of

a mild antiseptic (not full-strength iodine); and (3) by the application of sterile dressing until healed. A known disability may be easily guarded against; but, if unknown, the loss of a limb may be at stake.

Similarly, in every complete physical examination by a consultant or internist, the state of the peripheral vessels must be recorded. If they are found subnormal or absent, instructions similar to the above may be of untold value to the patient in avoiding trouble. Inadequate circulation may be endurable and without danger if uncomplicated by injury or infection. If infection is added to the disability of inadequate circulation, a vicious circle may be set up which threatens life itself.

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WILLIAM J. KERR, M.D. (University of California Hospital, San Francisco).—There is little to add to Doctor Pearl's discussion. The basic principles of value have been stated, and although many details of the tests may be added, enough have been mentioned to help the clinician in the analysis of the problem in each patient. When patients with circulatory disorders present themselves, it has been most helpful for me to keep in mind the structures and their functions which are important in the maintenance of the normal circulation to these parts. First, comes a careful description and location of the lesions; then a study of all the arteries of the body available for examination as to size, consistency and patency, with pressures and quality and volume of pulsations. The veins and lymphatics should be surveyed also. The nervous system and osseous system may be at fault and should be examined carefully. It may be necessary to determine the element of spasm in the causation of symptoms, and this can be accomplished by the methods mentioned. Usually simple methods are most helpful. Histologic examination of tissues may be necessary and many special studies may be required to determine etiologic factors. When all methods of examination are completed and the cause of the circulatory disturbance has been found, the outlook from treatment is too often very disappointing. Very little result of a permanent nature can be expected by any method of treatment in the progressive degenerative and proliferating diseases of the arteries. The symptoms and signs which are stated to be characteristic of certain vascular diseases of the extremities are usually due to alterations of function, and may be due to many types of primary lesions. The problem in industrial medicine and surgery is a difficult one. We can expect that many patients with faulty arterial supply to the extremities may continue for extended periods without symptoms and, following slight injury, develop serious lesions rapidly. We recognize this principle when we urge great precaution in the care of the feet in the arteriosclerotic and diabetic patient. The problem of industrial hazard is the same as in the cardiac, tubercular, or arthritic patient.

Paralytic and Preparalytic Poliomyelitis.—According to a note in *Public Health Reports*, two states have already instituted a classification for reporting cases of poliomyelitis into paralytic and preparalytic or nonparalytic types. The Department of Public Health of Massachusetts placed this classification in effect at the beginning of the present year. Effective October 20, a similar division was to be reported in the state of Tennessee. The number of cases of preparalytic poliomyelitis which are included in the total reported for that disease will be stated in each weekly report. These are nonfatal cases of poliomyelitis that have not shown definite muscular weakness. Because of the variability and uncertainty in recognition of nonparalytic poliomyelitis, it is believed that for recording and comparing intensity of spread of poliomyelitis only the paralytic cases should be counted when such distinction is possible. Any notable number of nonparalytic cases will be reported separately. There is no intention in this procedure to minimize the importance of the preparalytic or nonparalytic cases from the point of view of the spread of the disease or the necessity for medical care.—*Journal of the American Medical Association*, December 12, 1936.

THE LURE OF MEDICAL HISTORY†

THE HUNTERS IN EMBRYOLOGY*

By A. W. MEYER, M.D.

Stanford University

III **

WILLIAM HUNTER deserves great credit for regarding the decidua as a growth of the lining of the uterus instead of a coagulum. It seems that the idea that it was a coagulum was attributed to William through the text of 1794 to the Gravid Uterus, written by his brother John and Matthew Baillie.³⁰ The idea hence became current as that of William instead of John, perhaps because the 1794 text appeared later and had a wider circulation than the famous atlas itself. It is noteworthy that even von Baer,³¹ in his observations on the development of man, which appeared in 1835, spoke of the Membrana decidua hunteri as a layer of unorganized secretion lying upon and between the elongated villi of the pregnant uterus. Von Baer thought the blood vessels invaded this layer, growing around the villi and forming so complete a plexus that he could not distinguish the arteries from the veins. He believed that this indicated that the relation of the decidua to the uterus is that of an inflammatory exudate to the injured tissues, and added that he hesitated to regard the human decidua as a "proliferation of the mucosa as Seiler recently had done, and shared the more generally accepted opinion that it is a coagulum." In discussing the idea further, von Baer brought together a number of facts which he believed supported a view also held by Purkinje³² (1834).[§]

It may have been fortunate that John was probably unaware of the views of "eminent anatomists" referred to by Haller on this matter, unless he could also have known what Aranzi³³ and others had thought, and what Falconnet³⁴ and

†A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

*From the Department of Anatomy, Stanford University.

** Part I of this paper was printed in the November issue, page 420; Part II, in the December issue, page 492.

30 Hunter, William: An anatomical description of the human gravid uterus and its contents, edited by M. Baillie, London, 1794, 4to.; second edition, by E. Rigby, London, 1843, 8vo. (Cited after Bettany.)

31 Von Baer (Karl Ernst): Beobachtungen aus der Entwicklungsgeschichte der Menschen. Aus einem Schreiben an den Herausgeber. Journal für Geburtshilfe, 14:401-417. Leipzig, 1835.

32 Purkinje (J. E.): Das El. Anzeige aus dem "Encyclopädischen Wörterbuche der medicinischen Wissenschaften." Herausgegeben von den Professoren der medicinischen Facultät zu Berlin, Busch, Gräfe, Hufeland, Link und Müller. X. Band. 1834. 8: Journal für Geburtshilfe, 14:375-399. Leipzig, 1835.

§ Purkinje gives the following terms for decidua: Sandifort called it Decidua externa; Haller, Membrana externa ovi; Hunter, M. caduca or decidua; Mayer, Caduca crassa; Osiander, Membrana mucosa; Meckel, maternal egg membrane (mütterliche Eihaut); Chaussier, Epichorium; Danz and others, deciduous membrane (shedding skin); Bojanus, Decidua cellularis and spongiosa; Burdach, Nidamentum; Velpeau, Anhiste; Breschet, Membrana caduca primitive; Seiler, Membrana uteri interna evoluta.

33 Aranzi, Giulio Cesare: De humano foetu, etc. Third edition, Venet., 1587. First edition, 1564 (Rom.) or 1572. (Cited after Fasbender.)

34 Falconnet, Camillus: Non est fetui sanguis maternus alimentum. Paris, 1711. Also in Haller's Disputationes selectae, 1750. (Cited after Needham.)

others had done, in order to solve the vexed problem of the utero-placental circulation. Concerning the controversy between the two, Teacher regarded the account of William more probable than that of John. One cannot contemplate the rejoinder of William to John, made to the Royal Society on February 3, 1780, without noting its evasion and ambiguity. It must be wholly unconvincing except to those to whom the possession of stolen goods is conclusive proof of their rightful ownership, for that is a form of reasoning resorted to by William. Moreover, one cannot help wondering what experience William had that caused him to declare to his students that "... most philosophers, most great men, most anatomists, and most other men of eminence lie like the devil." Moreover, it is well to recall William's words regarding the fetal and maternal portions of the decidua as quoted by Teacher⁹ (p. lvi), which are to the effect that the vessels of these two parts are separate because "those of the umbilical always 'remained uninjected.' 'It was this appearance,' he says (in his lectures of 1775), 'in the cat and bitch that first led me into the apprehension that the human placenta was the same. I thought this a long time, but I never cared to assert it openly till within these few years.'"

Scrutiny of the Gravid Uterus does not seem to bear out the statement of Bilikiewicz³ (1932) that William Hunter was the first to investigate the uterine and fetal membranes with the greatest thoroughness, and that he described them in every detail so as to satisfy the high exactions of contemporary anatomy. Bilikiewicz also spoke of numerous discoveries in the field of anatomy and the anatomy of pregnancy by Hunter, which affected the further development of theories of obstetrics and also those of embryology, but added that the text of the Gravid Uterus comprised the whole of Hunter's anatomic-obstetrical science.

PLACE OF WILLIAM HUNTER IN EMBRYOLOGY

When considering the claims of William to a place in embryology, it must also be remembered that the Gravid Uterus contains some drawings of relatively young human conceptuses; one on Plate 33 being what Hunter quite correctly called an "eight-to-nine-week embryo," for the specimen seems to belong to an 18-millimeter stage and hence is only a little younger. It is interesting that William thought that the decidua is expelled at birth and in abortion, and that he represented the yolk sac and knew of its presence in the mature placenta.

In addition to the above claims to remembrance in the history of embryology, William has others, however. One of the chief of these is the fact that he encouraged and financed William Cruikshank in his search for the mammalian ovum in the rabbit. That Cruikshank was unusually successful in this difficult task is shown by the fact that he obtained more than a score of such very young blastocysts that von Baer wondered why this fine accomplishment had not led others to anticipate his own discovery by many years. It is of special interest that the results of Cruikshank's investi-

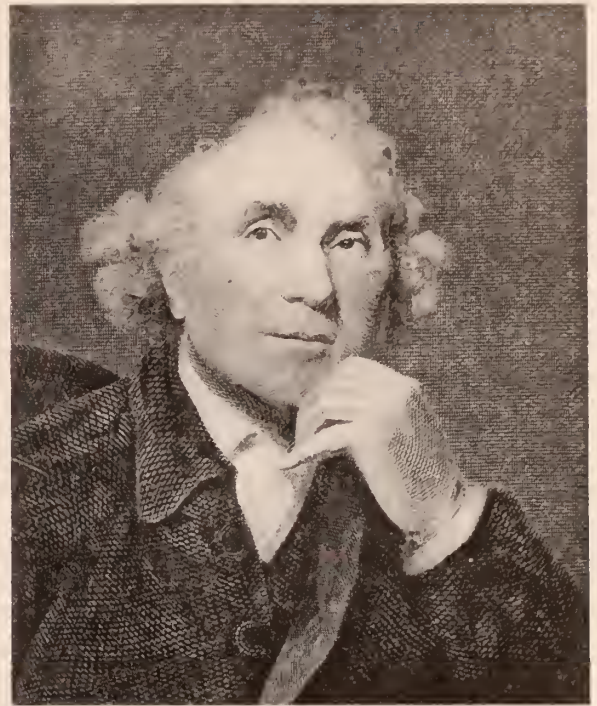


Fig. 1.—The Reynolds portrait of John Hunter from the works of John Hunter, F. R. S., with notes, edited by James F. Palmer. Plates. London, 1837.

gations upon rabbits had, according to his own words, been incorporated for nineteen years, in the lectures at the Great Windmill Street School, before they were finally reported to the Royal Society in 1797, through the instrumentality of Sir Everard Home, John's brother-in-law.

William's third and strongest claim to remembrance in connection with embryology is the fact that he gave John the opportunity he sought, to join him at the School of Anatomy, and thus afforded him an opportunity to develop his interests in natural history. It seems that John was then an unlettered and untrained, even if not also a spoiled and uncouth orphan of twenty years. He had been a failure in life thus far, but was stimulated so deeply by the activities permitted him by his apprenticeship to William that he had undertaken investigations on generation by 1755. This was within a year of the time when he had the exceptional opportunity to study and dissect a human uterus with fetus near term, injected by McKenzie, and the occasion on which John apparently rediscovered the independence of the maternal and fetal circulations. It seems that the cadaver had been injected through the uterine, and the unborn child through the umbilical vessels, and John said that he conceived the idea of the independence of the circulations while dissecting the placenta. Although he later wrote that his elder brother received the idea with "raillery," when he broached it to him at the time, it is a well-known fact that William maintained that it was his own discovery, and that he always had incorporated the idea in the first and only public lecture in the fall of every year. Had William sponsored the idea of the independence of the two circulations before 1754, it is extremely un-

likely that John would have remained unaware of it, and he hence would have had no occasion to think that he had made a discovery when dissecting the female body injected by McKenzie and so report to William. Moreover, according to Paget,³⁵ the manuscript notes taken by one who attended William's lectures in 1755-1756 show "that William Hunter, even then, a year after the discovery of the placental structures, neither spoke of it nor understood the meaning of it."—the uteroplacental circulation. These words also are in complete accord with those quoted above from Teacher, and also those from the anonymous auditor apparently written after the death of William, and if true, fully confirm John's statement regarding William's reaction to the idea. Moreover, careful scrutiny of the text written by William himself for his famous folio, published in 1774, twenty years after John's rediscovery, confirms Paget's view completely, for the independence of the two circulations is only implied, not represented or asserted there. However, it is not my purpose to cast lots between two famous men, but merely to show that John has better claims than William to a place in the history of embryology.

JOHN HUNTER'S INTEREST IN EMBRYOLOGY

John's interest in embryology was so enduring that he was still appealing for ostrich eggs almost forty years after he began his studies in embryology, and the very year of his death. Evidence of this is contained in a letter written by him to a friend traveling in Africa at that time. Since he had received only two ostrich eggs in thirty years, this certainly is eloquent testimony to his interest in the subject. I have considered the claims of John alone to a place in the history of embryology more fully elsewhere* and, in addition to the things mentioned, attention may also be directed to the collections which he assembled upon the subject. According to Ottley,³⁶ these illustrate various phases of comparative embryology, both normal and abnormal, and comprise 1,500 preparations illustrating reproduction in both plants and animals. The collection on the development of the ovum is said to be represented by three series:

"First, in plants which have no evident seeds; next, in gemmiparous animals, as the hydatid; next, in cryptogamous and phanerogamous plants; and lastly, in hermaphrodite animals, whether self-impregnating, as the asteria, the barnacle; or mutually impregnating, as snails, slugs, and other gasterapods." A sixth series of over four hundred fifty specimens is said to represent "the various conditions in which the eggs of oviparous animals are placed for the purpose of being hatched, and of the changes which take place in the young animal during the foetal state." The seventh and eighth series of specimens are said to represent

"the development of the ovum and its contents in Mammalia," and "the principal peculiarities of structure in the young animal during the foetal state, such as the yolk bag, and its connexion with the foetus; the foetal circulation in birds; the horny knob on the beak used in breaking the shell; the reception of the yolk into the stomach; the umbilical cord in Mammalia; the open foramen ovale; the ventricles of the heart of equal thickness; the situation and descent of the testes; the membrana pupillaris, and the large thymus gland." The ninth series is said to illustrate the growth of the young in both plants and animals, and the tenth, "various modes in which food and protection are furnished for the young animal." There also are said to be specimens in abnormal development illustrating the "preternatural situation of parts" and "the addition of parts."

I do not know whether some of the specimens in this collection, which seem rather apocryphal, were prepared by John himself, but I have long been curious to see the head of a duck with a limb arising from it, and the case of the "double skull, which belonged to a child of six years of age. The skulls are united by their vertices; the upper one was supplied by blood vessels passing through the united portions; and from the account given by eyewitnesses, the upper head seems during life to have experienced sensations, and to have exhibited mental operations distinct from those of the lower head." When one recalls the report given John by an enthusiastic Philadelphian, of the frequency of the occurrence of double-headed snakes in America, and if one makes allowance for the early state of embryology at the time, it is not difficult to see that an enthusiastic collector and a very busy man such as John Hunter, may at times have been imposed upon. If so, the matter scarcely justifies cavil now, for there can be no doubt about John's scientific enthusiasm, and his experimental approach to the problems which confronted him deserves much praise. It seems to me that his abiding interest and his accomplishments in the subject of development greatly exceeded those of the so-called iconographers, and that in spite of the fact that the many fine illustrations on the development of the chick and goose remain unknown, John deserves a place in the history of embryology much more than his brother William, upon the basis of iconography alone. It is true that John never finished the text on the hen or the goose, but surely he is not alone in being found by Chronos with an unfinished task. Moreover, the writing of these texts would have been an unusually difficult task for one who lacked linguistic training. He might have encountered insuperable difficulties in devising new terms, regarding which he had said: "To coin new words would not answer the purpose, because then I must have a dictionary of my own." Certainly no finer tribute could be paid John for his conclusion regarding the independence of the uteroplacental circulation in 1754 than the belief of Haller, in 1767, that "eminent anatomists" had proved that the two circulations were one.

Department of Anatomy,
Stanford University.

³⁵ Paget, Stephen: John Hunter, Man of Science and Surgeon (1728-1793). With introduction by Sir James Paget. London, 1897.

* CALIFORNIA AND WESTERN MEDICINE, Vol. 43, August-November, 1935: "Mr. John Hunter on Generation."

³⁶ Ottley, Drewry: The Life of John Hunter. In lectures on the principles of surgery by John Hunter, with notes by James F. Palmer. Philadelphia, 1839.

CLINICAL NOTES AND CASE REPORTS

ACUTE DIFFUSE GLOMERULONEPHRITIS*

By JESSIE M. BIERMAN, M.D.
San Francisco

HISTORY.—Case 56975: An eleven-year-old boy was the son of healthy parents and had been well, except for having measles, chickenpox and scarlet fever in mild form in early childhood. On December 17 he complained of sore throat and was feverish. He was put to bed and remained there for several days, after which he seemed perfectly well until January 5, when he complained of headache and his mother noticed that his face was swollen. The following day he vomited, and the swelling and headache became more marked. On January 8 he retained no food or fluids, and seemed very ill. Next day he suddenly complained of being unable to see and his head began to jerk. He soon lapsed into unconsciousness and was brought to the Children's Hospital on January 9.

Physical Examination.—He was a very well-nourished and well-developed boy, whose face was pale and very edematous. It was impossible to arouse him during the examination. Breathing was deep and quiet. The skin was warm and moist. The neck was not stiff. The pupils were equal and reacted to light. There were conjunctival hemorrhages in both inner canthi. The retinal vessels were of normal appearance. There were no hemorrhages or exudate. The breath had a uriferous odor. The teeth contained several small cavities. The gums were healthy. The tonsils were large and injected. There was no post-nasal discharge. Several small discrete glands were palpable in the posterior cervical regions. The pulse was slow, regular and bounding. The cardiac impulse was visible in the fifth interspace inside the midclavicular line. The area of cardiac dullness was not increased. Both sounds were clear and of good quality and rhythm. The blood pressure was 162 systolic, 108 diastolic. The lung fields were clear. The abdominal wall was thick and relaxed. The liver was not enlarged. The kidneys and spleen were not palpable. The percussion note was tympanitic over most of the abdomen. There was no flatness in the flanks. The extremities were relaxed. Slight pitting edema was present in both ankles. There was no desquamation of either the palms or the soles. The patellar, ankle, and plantar reflexes gave normal response, but were hyperactive. The rectal temperature was 96.4, the pulse 74, the respiration 18.

Shortly after the examination the boy aroused and complained of frontal headache. A small amount of amber-colored cloudy urine was passed. It was strongly acid, of a specific gravity of 1.032 and contained a heavy cloud of albumin (over one per cent), no sugar, a large amount of acetone, a trace of diacetic acid. After centrifugalization the sediment was found to contain seven to ten red blood cells, ten to twelve white blood cells, and two to five casts in each high dry field. The casts consisted chiefly of finely and coarsely granular forms, with occasional hyaline and red blood cells forms. The hemoglobin was 95 per cent with 5.9 M red blood cells. The leukocytes were 15,200 with 98 per cent polymorphonuclears.

Diagnosis.—The history of puffiness of the face and headache occurring about three weeks after sore throat suggests at once the diagnosis of acute nephritis.

The delay in appearance of symptoms after the acute infection, the non-dependent edema, the rise of blood pressure, the early appearance of cerebral symptoms and the small amount of blood in the urine, speak for acute diffuse glomerulonephritis, with eclamptic symptoms (Vollhard-Fahr), as against focal nephritis, in which usually gross hematuria appears during the course of acute infectious diseases, and is not likely to be accompanied by more than slight hypertension and edema.

The history of scarlet fever previously and the absence of rash with and of desquamation following the sore

throat preclude this as a cause of the trouble; although postscarletinal nephritis often takes this form. That we are not dealing with chronic glomerulonephritis with uremia is indicated by the history of previous robust health, lack of anemia, normal heart contour and sounds, high urinary specific gravity, normal eye-ground findings, and the eclamptic type of cerebral symptoms, as contrasted with the slowly developing asthenic uremia of failing kidneys. Other causes of convulsions and coma, such as cerebral injury, diabetes, encephalitis, epilepsy, are easily ruled out.

Progress and Treatment.—Ten cubic centimeters of 25 per cent solution magnesium sulphate was given intramuscularly shortly after admission. This was followed by an intravenous injection of 150 cubic centimeters of hypertonic (25 per cent) glucose solution. A few hours after regaining consciousness, irregular nystagmus and clonic convulsions of the neck and face muscles began. This was followed by involvement of the right arm and leg, and became generalized after ten minutes. The blood pressure rose to 180/140. Three grains of sodium phenobarbital was given intramuscularly, and two more intramuscular injections of magnesium sulphate, at hourly intervals. The blood pressure dropped to 136/100 at the end of two hours, and convulsions ceased. The following morning the blood pressure was 160/110, the patient was conscious and fairly comfortable. The blood pressure gradually rose, and as it reached 174/120 twitching began. By noon it had reached 198/120, the patient was unconscious and convulsing severely. After large doses of magnesium sulphate, given both intravenously and intramuscularly, the blood pressure fell to 146/98 and convulsions ceased. The next day he was much better in every way. The blood pressure did not rise above 160/106, and headache and nausea had disappeared. Magnesium sulphate was continued by mouth until the fifth day, when the blood pressure had reached 100/70 and all edema had disappeared. The diet consisted of milk, fruit juices freely, vegetables, and restricted salt.

The blood nonprotein nitrogen, taken upon entry while the patient was unconscious, was 37.5 milligrams per 100 cubic centimeters.

An Addis count performed on a concentrated twelve-hour specimen of urine, done a week after entry, showed: Volume, 250 cubic centimeters—acid; specific gravity, 1.028; albumen, 3 per cent (Esbach); red blood cells, 8,265,277 (normal, under 500,000); white blood cells and epithelial cells, 901,388 (normal—under 2,000,000); casts, 61,111 (normal—under 5,000); 50 per cent granular—25 per cent red blood cells and 25 per cent hyaline.

Subsequent Addis counts showed gradual decrease in red blood cells, casts, and albumen.

The patient was dismissed on January 30 and has since been followed in the out-patient clinic. At the last examination, done ten months after onset of the nephritis, the blood pressure was found to be 110/75; the hemoglobin 85 per cent, with 4.5 M red cells. The Addis test showed: Volume, 250 cubic centimeters—clear, amber, acid; specific gravity, 1.031; no albumen (qual.); red blood cells, 2,497,000; white blood cells and epithelial cells, 519,000; casts, 27,750 with about equal numbers of red blood cells and finely granular casts. A number of routine urine examinations, done by the clinic laboratory, had been reported normal.

Prognosis.—The matter of complete recovery from acute diffuse glomerulonephritis in childhood is a subject of considerable difference of opinion among various observers. Undoubtedly many cases have been dismissed in the past as cured because careful quantitative studies of the urinary sediment under proper conditions have not been done. It is notable that, in this case, after ten months the output of red cells in the urine is still considerably above normal (500,000), yet their presence was missed in a dilute specimen of urine examined in the usual routine way. The presence of red blood cell casts is further indication that healing has not taken place. The high specific gravity denotes good functional ability.

The disease is now in the latent stage, and there is about an even chance that all traces of activity will subside within three years after the onset. If healing does not take place within this time, little chance for ultimate recovery can be anticipated.

384 Post Street.

*From the Department of Pediatrics, Children's Hospital, San Francisco.

MEDULLOBLASTOMA*

REPORT OF CASE

By EDWARD LEEF, M.D.
San Francisco

THE case we are presenting is of medulloblastoma in a girl of seventeen, first seen by us October 17, 1930, and still living. The purpose in presenting this case is to emphasize the need of thorough roentgen treatment to the entire cerebrospinal system, following decompression and removal of all or part of the tumor.

NATURE OF MEDULLOBLASTOMA

Medulloblastoma is one of the gliomata in which the cells represent an embryonic stage earlier than either the spongioblast or the neuroblast. These are rapidly growing cellular tumors occurring most frequently in children, in the central part of the cerebellum, usually arising from the roof of the fourth ventricle. This type of glioma frequently invades the subarachnoid spaces; and after operative removal of the primary tumor, there are likely to be implants along the spinal region. Bailey and Cushing¹ first described these tumors in 1925, presenting twenty-nine cases. They describe the microscopic appearance of these tumors as being composed of rounded, or pear-shaped, sometimes spindle-shaped cells with scanty cytoplasm and big oval nuclei containing an abundant network of chromatin. The cells appear as a loose structureless mass, but the nuclei occasionally arrange themselves in pseudo-rosettes or lie in strands. The case which we are reporting may be described as a very cellular tumor with the cells divided into groups by fibrous stroma. The cells have a moderate amount of cytoplasm and large, round, granular nuclei, a number of which show mitotic figures. The tumor is quite vascular and in places tumor cells are found invading the blood vessels (Figs. 1 and 2).

* Read before the Cancer Commission of the California Medical Association at its conference at Yosemite, May 12, 1935.

TREATMENT

In treatment, authors are agreed that the medulloblastoma is quite susceptible to radiation; that suboccipital decompression should precede irradiation, and that normal brain tissue is not injured by irradiation.

Bailey and Cushing,¹ in the cases reported in 1925, found that those that survived the operation and were not treated (nine cases) had an average survival of seven months; while those treated with radiation, including only those who have died (ten cases), had an average survival period of nineteen months.

Bailey, Sossman, and Van Dessel,² in 1928, reported eleven cases and found that roentgen treatment retarded the growth of the tumor, so that the average survival period of the treated cases was thirty-four months.

Bailey,³ in 1930, reported four such patients who received more thorough treatment than any of the others. He found that recurrence of the symptoms, with ultimate fatality, was the rule. Each of these patients was given several courses of deep therapy over the entire brain and spine.

Cushing,⁴ in 1930, reported sixty-one cases, thirty-one of which received x-ray therapy in varying amounts from one to twenty courses. The average survival period of these patients was fourteen months, one patient living as long as five years and three months before death.

Tracy and Mandeville,⁵ in 1931, reported three patients improved by x-ray therapy. They advised thorough deep roentgen therapy over the entire cerebrospinal system following operation, repeating the cycle two to four times during the first year.

¹ Bailey, P., and Cushing, H.: Medulloblastoma Cerebelli, *Arch. Neurol. and Psychiat.*, 14:192-223, 1925.

² Bailey, P., Sossman, M. C., and Van Dessel, A.: Roentgen Therapy of Gliomas of the Brain, *Am. J. Roentgenol.*, 19:203-264, 1928.

³ Bailey, P.: Cerebellar Medulloblastomas, *Am. J. of Pathology*, 6:1925-1935, 1930.

⁴ Cushing, H.: Experiences with the Cerebellar Medulloblastoma, *Acta Radiologica*, 7:1-85, 1930.

⁵ Tracy, F. E., and Mandeville, F. B.: Roentgenotherapy of Medulloblastoma Cerebelli, *Radiology*, 17:259-263, 1931.

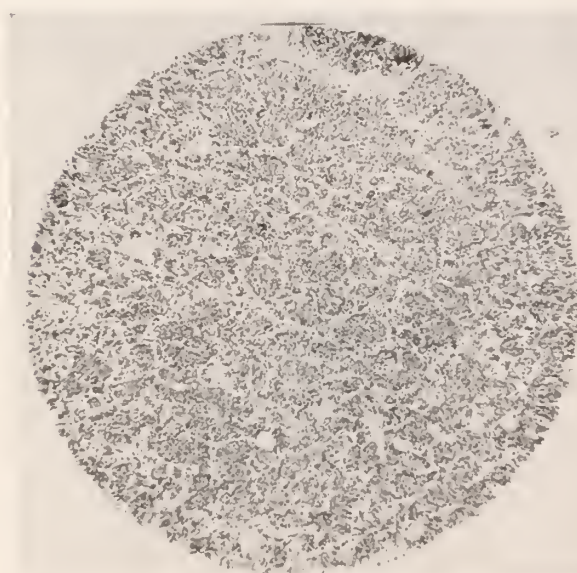


Fig. 1.—Low-power photomicrograph. This shows the grouping of the cells.

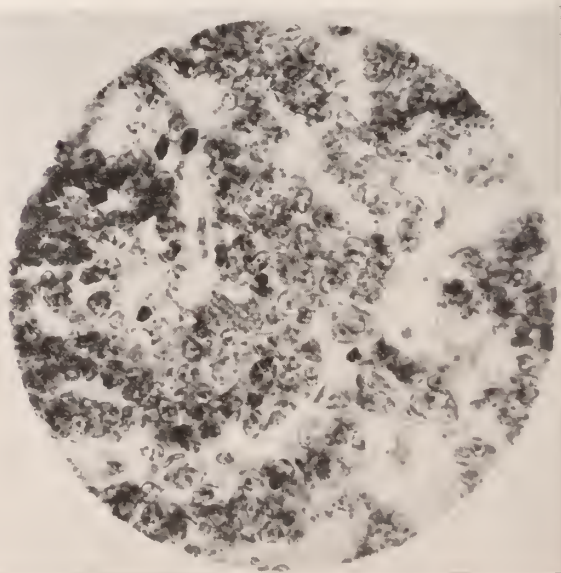


Fig. 2.—High-power photomicrograph. This shows the large round granular nuclei.

Brody and German,⁶ in 1933, reported fifteen cases in six of which the patients received intensive radiation to the entire cerebrospinal system, and five of whom were still living with an average duration of twenty months.

REPORT OF CASE

We have had several cases of medulloblastoma, but the case which we are reporting is Miss E. S., age 17, whom we first saw October 17, 1930. At that time her complaint was pain and numbness in the left leg, followed by loss of strength in it during the last week. The pain, severe cramp-like in character, started suddenly in the outer aspect of the left leg and spread to the whole leg, thigh, and foot. After a week's rest in bed the patient felt less pain, but the left leg felt numb and became progressively weaker until finally the limb became paralyzed. It was in this condition that the patient entered the hospital.

The past history was not important.

Examination of the patient showed a young girl without any complaints excepting those mentioned before. She was pleasant, bright, and did not appear to be seriously ill. All systems were normal excepting the nervous system, and here we found several pathologic changes.

Brudzinski's and Kernig's signs were positive on the left side.

Knee-jerks were absent on the left side.

Ankle-jerks were absent on both sides.

Babinski's sign was positive on the right side.

There were diminished abdominal reflexes on the left side.

There was parasthesia over the left leg and thigh.

There was hyperesthesia over the right leg below the knee.

There was flaccid paralysis of all of the muscles of the left foot and toes, and partial paralysis of the muscles of the left leg and thigh.

There was no involvement of any of the cranial nerves.

There was no evidence of increased intracranial pressure.

The clinical diagnosis during this time was the paralytic stage of anterior poliomyelitis. However, weakness became progressive until October 30, 1930, when both the right and left lower extremities had become totally paralyzed. Then, on November 1, 1930, a spinal puncture was done and no fluid obtained. A combined cisternal and lumbar puncture on November 4 showed clear cisternal fluid and, with pressure, a few cubic centimeters of yellow spinal fluid was obtained. At the same time 1.2 cubic centimeters of lipiodol was injected into the cisterna. This lipiodol descended only as far as the upper level of the third lumbar vertebra (Fig. 3). On November 6, 1930, Doctor Reichert did a laminectomy, and upon opening the dura he found a tumor extending from the third to the fifth lumbar vertebrae. The tumor was dissected free and removed. After this there was a gradual return of the reflexes to normal or toward improvement. Deep x-ray therapy was given starting the twelfth day after operation, the lumbar spine receiving 600 r, both anteriorly and posteriorly, in four days.

On November 23, 1930, the patient was sent home, being much improved. By February 26, 1931, she was walking fairly well. By June 3, 1931, she was able to walk and dance well. On June 4 the patient was started on another four-day course of deep therapy, 200 roentgens being given each day to the lumbar spine posteriorly.

The patient got along quite well and was not heard from until October 27, 1931, when she returned complaining of some disturbance in vision, pain between the shoulders, and parasthesia in both arms. Deep x-ray therapy was given again, this time to the cervical and upper dorsal spine, 200 r daily, alternating anteriorly and posteriorly for ten days. After the third treatment all symptoms had disappeared.

December 2, 1931, the patient returned again complaining of headache and dizziness, and vomiting of ten days' duration. Examination showed no disturbance of the cranial nerves, and the reflexes were unchanged. The



Fig. 3.—This shows the lipiodol stopped at the level of the third lumbar vertebra.

following day Doctor Reichert did a suboccipital decompression and exploration. This disclosed the fourth ventricle infiltrated with tumor, about half of which could be removed. The postoperative course was stormy. On December 29, 1931, autopsy and undertaker permits were signed by the father. Deep x-ray therapy, having been started December 17, 1931, was being applied at this time. These treatments were given daily to the head, alternating right and left, 100 to 125 r each time, for twenty-two days.

A few of the progress notes at this time are as follows: December 12, 1931, the patient lies in a stupor, does not respond.

December 17, condition unchanged.

December 24, the patient is not quite so drowsy.

December 29, condition grave.

January 4, 1932, more alert, able to see.

January 12, talks intelligently and is enthusiastic.

January 17, up in a chair.

January 18, walked a few steps.

January 21, dismissed; walking with help.

Later, because there was a region of the cord still untreated, the patient was given another course of deep therapy to the middle and lower thoracic region. Treatments were given posteriorly for seven days, 150 r each time.

June 4, 1932, the patient again returned, this time complaining of occasional vomiting and blurring of vision in the right eye. Deep therapy was given to the cerebellar region, 100 r daily for two weeks. Improvement was definite by the end of the course, and when she returned for a check-up three months later she was feeling fine. On January 17, 1933, the patient reported again, stating that she had danced all but three dances on New Year's eve.

Further observations were made during 1933 and 1934. She felt well, except that the menses had not returned.

She was seen for the last time in June, 1935, feeling well as before. She told us she was getting married shortly.

CONCLUSION

This case is similar to some reported by others.

1. The tumor was widespread.

2. The tumor was radiosensitive.

3. Irradiation covered the brain and spinal cord. Stanford University Hospital.

⁶ Brody, B. S., and German, W. J.: Medulloblastoma of the Cerebellum, *The Yale Journal of Biology*, 6:19-29, 1933.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

CONVULSIONS IN CHILDREN

I. ETIOLOGY

ROLAND P. SEITZ (490 Post Street, San Francisco).—The increased irritability of the nervous system plays an important part in the frequency with which convulsions occur. According to Morse,¹ the higher cerebral centers, inhibitory in action, are yet imperfectly developed and are thus less able to restrain discharges from lower centers than when perfect development occurs.

Heredity is likewise predisposing, and convulsions are infrequent in families with a stable nervous background. The clinician notes evidence of nervous disease in the parents of convulsive children with striking regularity; or one parent discloses that similar attacks occurred often in his or her childhood.

Excepting the first month of life, the commonest cause of convulsion is acute infection and this precipitates about a third of all attacks during childhood.

In the neonatal period most convulsions are on an organic basis associated with cerebral birth injury or intracranial hemorrhage. Recent reports indicate that not a few at this early age are due to tetany or spasmophilia. Proved cases show a serum calcium of 7.5 milligrams or less per 100 cubic centimeters of blood; probable cases respond to the administration of calcium salts. Acute infection and sepsis are not rare, and the navel may be the portal of entry.

Both Peterman² and Brown³ have recently presented statistical studies of the etiology of convulsions in childhood, and their results appear in Tables 1 and 2 respectively. Comparison is interesting and shows notable differences.

Acute infection is most often respiratory; but sepsis, pyelitis, otitis and the contagious diseases are commonly the exciting cause. Enteritis is usually infectious and most often encountered in

TABLE 2.—*The Incidence of Convulsions Among 400 Children (After Brown)*

Diagnosis	Number	Per Cent
Acute infection	120	30
Acute nutritional (G. I.)	11	2.7
Acute C. N. S. disease....	62	16.5
Infantile tetany	45	11.3
Cerebral deficiency	38	9.5
Cerebral birth injury	34	8.5
Intracranial hemorrhage	9	2.3
Plumbism (Encephalitis 5)	9	2.3
? Epilepsy	6	1.5
Miscellaneous	41	10.2
? Etiology	25	6.2
	400	100

the first six months of life. Some individuals have a low temperature threshold, and will manifest nervous symptoms regularly with a temperature of 102, while others are little affected in this regard by true hyperpyrexia.

Acute disease of the central nervous system with convulsions is most often meningitis. The B. influenzae, pneumococcus and streptococcus hemolyticus are repeatedly obtained on culture of the spinal fluid. Meningococcic meningitis, tuberculosis and syphilis are more rare. Other diseases will include encephalitis, plumbism, poliomyelitis and tetanus.

What of epilepsy? Is it true that every child who has a convulsion is a potential epileptic? It is well to remember that the convulsion in epilepsy is not accompanied by any visible pathological features and it occurs most frequently between the ages of 5 and 10 years. The epileptiform convulsion is transient, impairs or causes loss of consciousness, and must ultimately result in some change in the personality of the patient. Morse¹ followed a series of private patients in whom he had witnessed one or more convulsions for as long as twenty years. He concludes "most positively, there is no way to determine immediately when a baby or child has convulsions or repeated attacks suggesting petit mal, whether it has epilepsy or whether it will develop it later." He also affirms that the presence of an apparent cause for an attack does not, however, exclude epilepsy and this should not be forgotten. Hosen⁴ claims general statistics compiled by neurologists show that 22 per cent of the cases of infantile convulsions later develop epilepsy as compared to the pediatrician's 7 per cent.

Reflex convulsions must be almost negligible in spite of fanciful medical and lay beliefs associated with worms, teething, phimosis, et al. The ob-

1. Morse, J. L.: Am. J. Dis. Child., 19:73, 1919

2. Peterman, M. G.: J. A. M. A., 102:1729, 1934.

3. Brown, J. E.: Ohio State M. J., 31:423, 1935.

TABLE 1.—*The Etiology of Convulsions Among 500 Children (After Peterman)*

Diagnosis	Number	Per Cent
Epilepsy (idiopathic)	165	33
Acute infection	115	22.8
Cerebral birth injury or residue	76	15.4
Spasmophilia or tetany..	68	13.6
Miscellaneous	44	8.8
Cause unknown	32	6.4
	500	100

4. Hosen, H.: J. Pediat., 4:636, 1934.

scure case may require, in addition to the usual examinations and laboratory work, special investigation of the blood chemistry, dextrose tolerance tests, examinations of the spinal fluid, encephalograms, examination of the fundi, roentgen examinations, and yet remain undiagnosed after months of observation.

* * *

II. SYMPTOMS AND DIAGNOSIS

ARTHUR A. BIRD, M. D. (3022 East Fourteenth Street, Oakland).—Symptoms of convulsions have a wide range in severity, power, and amplitude.

The mildest is a momentary lapse of activity, a staring away into space for a few seconds or a partial closing of the eyelids, with resumption of activity where it was left off.

This has been designated an "absence," but can be so persistent in recurrence as to constitute a major disabling condition.

A single muscle or local group, one side of the body or the entire voluntary muscular system may participate, almost always with loss of consciousness.

The eyeballs will usually rotate upward and outward, to left or right; the pupils be dilated, unequal, reacting sluggishly to light, or not at all until the paroxysm is about over.

More or less back, neck and head bowing occur with cyanosis from reduced breathing rate and closing of epiglottis consequent upon the muscular rigidity.

The usual sequence is a sudden stiffening or tightening of the body, held so for some seconds as tonic part or phase. This is then followed by the intermittent relaxation and tightening or jerking phase, the clonic movements.

The time element may be from one minute to twenty minutes or more, and the frequency may be a single one or become almost continuous as in status epilepticus.

The diagnosis is rather apparent, but may take days to complete the differential. This lies in determining whether it is central or from acute infection, toxic from so-called absorption, uremic, which is doubtful or tetanic with Chvostek's sign, and carpo-pedal spasm.

It may be, but is usually not epileptic, occasionally eclamptic in type in very young infants.

* * *

III. TREATMENT

HUGH K. BERKLEY, M.D. (1136 West Sixth Street, Los Angeles).—It is obvious that the treatment of convulsions in children must vary between wide limits because of the wide variations in the causative factors. Similar treatment could not apply to the convulsions due to high fever and the convulsions of tuberculous meningitis.

Our discussion of treatment must, therefore, be more general than specific. Specific treatment can only be intelligently instituted after a complete study of a given case and the discovery of the etiological factors involved.

For the convenience of discussion we have adopted the following classification:

1. Immediate treatment.
 - (a) During the convulsion.
 - (b) After the convulsion.
2. Prophylactic treatment.

Immediate Treatment:

The majority of convulsions occurring in childhood are those of febrile origin; that is, convulsions occurring as an accompaniment to the high temperatures associated with the various acute illnesses of childhood. In this type of convulsion the character of the infection plays little part either in the duration, the severity or the treatment. Here the essential factors involved are the effects of a high temperature upon an unstable nervous system. Many children are so nervously constituted that a convulsion regularly occurs when their fever passes their convulsive threshold.

These convulsions are self-limited and will usually cease in a short time, even if untreated. When treatment can be instituted it should be directed toward lowering the temperature. Satisfactory methods of accomplishing this during the attack are hot baths or hot packs, ice bags to the head, or tepid sponges of water or alcohol. With the resultant drop in temperature the convulsion usually terminates.

If unusually severe or prolonged, a few whiffs of chloroform may be of advantage. Such a procedure is rarely necessary, and if required should make one suspect that the fever alone is not the cause of the convulsion.

After the convulsive seizure has stopped, other more effective antipyretic measures may be employed. The outstanding drug for this purpose is aspirin. This drug is almost universally well tolerated, even by very young children, and is very effective in its antipyretic properties. The dosage should be large enough to be effective.

To raise the convulsive threshold, sedatives may be given in addition to aspirin. The following drugs are usually effective: sodium bromid, barbiturates, magnesium sulphate, morphin and chloral hydrate. These are named in the order of choice.

As soon as these measures have been carried out, it immediately becomes the duty of the physician to ascertain the cause of the fever and institute such remedial measures as are appropriate for the infection found to be present.

Prophylactic Treatment:

To know which child will be subject to convulsions and which will not is, of course, impossible. When, however, a child has established his tendency in this direction by having a convulsion, it may be fairly predicted that he will have others under similar circumstances. It seems wise, therefore, to so inform the parents and clearly outline to them the measures to be taken at the onset of fever. By the early and proper use of antipyretics and sedatives many of these children may be safely guided through their febrile disturbances without further convulsions. With each year of

added age the tendency to convulsions becomes less marked, and after the tenth year they are comparatively rare even though sedatives are not used.

For those convulsions which are not produced by fever the procedure employed must vary with the various etiological factors involved. In this group the convulsions of epilepsy occupy the major position. The immediate treatment for the epileptic consists in getting the patient into a safe, comfortable position. Clothing should be loosened, and some firm but pliable object placed between the teeth to prevent the subject injuring his lips or tongue by biting. It is usually unnecessary to stop the convulsive seizures of epilepsy—they are self-limited. The prophylactic treatment of epilepsy is so complicated, and involves so many factors that it is without the scope of this discussion.

The convulsions occurring in the course of the various forms of meningitis are usually due to the cerebral irritation of the infection itself or the pressure produced by it. Pressure can be controlled by lumbar punctures at such intervals as are found necessary. In cases of spinal blocks, resort may be made to cisternal punctures. When the convulsions are due to meningeal irritation rather than to pressure, the barbiturates furnish a satisfactory solution in most instances. Dosage should be sufficiently large to produce the desired effect. In some few cases where a fatal result is certain, the use of morphin is highly satisfactory.

It is now well known that some convulsive seizures in children are due to a functional hypoglycemia. If the blood sugar has been established to be below 60 milligrams per cent during or at the end of a convulsion, hypoglycemia may be considered as a possible causative factor. In such instances glucose intravenously produces spectacular relief. As an emergency measure epinephrin by hypodermic injection will be effective until glucose may be given.

On occasions convulsions will occur with the more severe paroxysms of whooping cough. Usually such convulsions are due to anoxemia and are relieved by removing the obstructing mucous. Gagging the child by the finger to produce vomiting is often effective. Inverting the child may relieve the obstruction by gravity. Such cases, fortunately, are very rare.

In the convulsions of accidental strychnin poisoning, and the convulsions of tetanus infection, the barbiturates are usually effective. The intraspinal or intramuscular use of magnesium sulphate is effective. Dosages should be accurately computed by body weight.

A convulsive seizure in a child is a terrifying thing to the parents or relatives. To the physician it should be indicative of a severe illness, but not terrifying. At few times in a physician's career is it so necessary to remain calm and collected, and to impart this attitude to those around him. His calmness is most essential, and in many instances it is the most effective treatment for those primarily and secondarily involved in such trying circumstances.

Insecticide Makers Punished for Labels Lacking "Inert."
The failure of manufacturers to place on the labels of their products the ingredient statement required by the Federal Insecticide Act formed the basis of the majority of prosecutions recently terminated under that statute, the Food and Drug Administration reports. The Act provides that if a preparation contains an ingredient inert against insects or fungi, the label must bear an ingredient statement. The manufacturer has the option of stating upon the face of the principal label of an insecticide, fungicide, or disinfectant, either the name and percentage amount of each and every inert ingredient contained therein and the fact that it is inert, or the name and percentage amount of each and every active ingredient, together with the total percentage of inert ingredients.

After a plea of guilty, the Huntington Laboratories of Colorado, Inc., Denver, Colorado, was fined \$150 for shipping in interstate commerce a misbranded disinfectant called "San-Pheno." The preparation contained more than 65 per cent of water, and the label failed to bear the ingredient statement required by the Insecticide Act. The product was represented as being positive in bactericidal action and high in germicidal strength, and was recommended for disinfecting purposes, including the disinfection of surgical instruments. It was ineffective when used as a disinfectant at the dilutions specified. This was considered particularly serious where the product is used in operating rooms for the disinfection of the hands and surgical instruments, since the failure to disinfect under these circumstances is a source of potential danger of infection to the patient.

The Coöperative G. L. F. Mills, Inc., Buffalo, New York, pleaded guilty to two informations charging violation of the Insecticide Act in the misbranding and adulteration of "G L F Copper Lime Dust" and misbranding of "G L F Lime Sulphur Solution." The latter product contained more than 68 per cent of water, and the label bore no ingredient statement. The Copper Lime Dust fell below the professed standard and quality under which it was sold, containing less than the 15 per cent of calcium arsenate claimed on the label. A fine of \$150 was imposed. . . .

Two moth preparations, "Aroma Moth Vaporizer" and "Termox Mothproofing Crystals" were the subject of a criminal prosecution against Ben Berg and Sol Nathan, trading under the name of the Berg and Nathan Sales Company, Chicago, Illinois. The "Aroma Moth Vaporizer" consisted of less than 2 per cent of paradichlorobenzene and more than 98 per cent of sodium chlorid (common salt), an inert ingredient not stated on the label, and was recommended for the control of moths in closets, trunks, dresser drawers, and garment bags, and for packing away furs and blankets. It was ineffective for the control of moths. The "Termox Mothproofing Crystals" contained about 60 per cent of common salt, and no ingredient statement appeared upon the label. A plea of guilty was entered and a fine of \$25 imposed.

Primary Streptococcic Peritonitis.—Analysis of forty-two cases of streptococcic peritonitis leads Pollock to believe that the condition can be readily recognized in most instances when it is recognized that it is seen most frequently in infants, that it is usually preceded by pharyngitis, that the abdominal symptoms, early distention and constant pain and tenderness, are generalized and start from two to three days after the subsidence of the infection of the respiratory tract, and that the condition is definitely diagnosed by abdominal puncture, the Gram-positive streptococci with pus cells being pathognomonic. The treatment depends on the severity and stage of the illness, each case being a rule unto itself. The mortality, at its lowest, is 80 per cent. The frequent severe sepsis interdicts early operation, while the peritonitis is generalized. In the interim, a continuous intravenous drip of saline solution, repeated transfusion of blood and the injection of pooled antistreptococcus serums is indicated. Laparotomy is valueless and even dangerous when the sepsis is severe. However, when the general infection is not marked and there is evidence of much peritoneal fluid, improvement is often observed when drainage is obtained by the simplest and most rapid means. The large walled-off abscesses should be drained.—*Archives of Surgery*, October, 1936.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

EDWARD M. PALLETTE President
HOWARD MORROW President-Elect
W. W. ROBLEE Speaker
MORTON R. GIBBONS Council Chairman
FREDERICK C. WARNSHUIS Secretary-Treasurer

THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *American Medical Association Secretaries' Conference.*
2. *Syphilis.*
3. *County Secretaries' Annual Conference.*
4. *Your Advertisers.*
5. *Copyright Protection.*
6. *Dues.*
7. *Empty Saddles.*
8. *Scientific Exhibits.*
9. *Del Monte Meeting.*
10. *Meetings.*
11. *"Quit Kicking Secretaries Around."*
12. *Optional Defense.*
13. *Executive Committee.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Children's Bureau Welfare Program.*
2. *Syphilis.*
3. *Radio Broadcasts.*

ASSOCIATION ACTIVITIES

AMERICAN MEDICAL ASSOCIATION SECRETARIES' CONFERENCE

In the last issue a summary of the address delivered to the conference by Surgeon-General Parran was published. That summary was sent by air mail to the printers. That issue went to press before the conference ended. A general summary will now be made.

The conference was opened by Chairman Rock Sleyster of the Board of Trustees. He traced the physical expansion of the Association during the past twenty-five years and closed by describing the remodeled headquarters building. During the past year a quarter of a million dollars was expended in remodeling. This expenditure has provided a very satisfactory exterior and interior that is a credit to the profession.

President Gordon Heyd of New York cited certain epochs in the history of medicine. He ascribed the survival of medicine through the ages and through changing times as being due to our ability to organize. The medical profession must concern itself with research and discoveries and then must see that its knowledge and resource obtain the widest possible distribution for the good of all people in all divisions or classes of society. He ended by stating that no matter what schemes, plans, or agencies were created, the providing of medical care would continue to require personal communion with a physician.

Malpractice suits and insurance was discussed. The increases of these suits were reported throughout the country. State organizations employ various means to protect its members.

In Chicago, newspaper editors were induced, by threats of suits for libel, to refrain from printing items that reported the initiation of a malpractice suit against a doctor. One out of every twenty physicians will be sued this coming year because of lucrative returns that lawyers

obtain from this racket. The possibility of being a defendant is ten times as great as having a fire in a doctor's office. The principal factor that inspires such suits is the criticism by a doctor of the treatment or services rendered by another doctor. In spite of almost constant warnings this breach of conduct continues, and until the time arrives when medical men desist making adverse comment, malpractice suits will continue to harass practitioners.

The American Medical Association trustees have determined to discontinue the publication of the *Monthly Bulletin*. A new department will be created in the *Journal of the American Medical Association* for the dissemination of association news.

The operation of the Michigan Filter System was described by the secretary of that state. The plan is coordinated social service that determines an individual's eligibility for charity services.

Dr. Glenn Myers of Los Angeles, by invitation, presented the plan of organization and operation of the California Public Health League. An interesting discussion was engaged in.

Mr. Holloway of the Bureau of Legal Medicine and Legislation discussed basic science laws and reviewed the effects of this form of legislation. California, New York, and Michigan are planning to obtain this form of legislation that is now in effect in eleven states. More will be said on this subject when our special committee presents its report.

A resolution was adopted urging that all state journals be protected by copyrights so as to prevent "throw away publications" from "lifting" scientific articles which, in the main, constitute the reading material in these pseudo-medical journals.

Warning was given that unless physicians were more careful in observing and complying with the federal narcotic laws that new legislation would be enacted that would be more rigid and would enforce greater restrictions to the embarrassment and inconvenience of practitioners.

Because of increasing correspondence, now tremendous in volume, the Bureau of Legal Medicine and Legislation has been compelled to restrict its services. Hereafter correspondence relating to legal and legislation questions will only be conducted through state secretaries. Individual members and county societies are urged to present their questions and problems to the secretary of their state organization and refrain from writing to the American Medical Association Bureau.

The value of these conference have been established. They afford an unusual opportunity to gain first-hand information and ascertain the functionings of sister state organizations. This year there was a universal sentiment that medicine must adapt itself to changing conditions and aid in molding federal and state plans for medical care for dependents along lines that will be acceptable to medical practitioners. Each state and each large metropolitan area must assume and meet their particular health and medical problems in a way that is best suited for each commonwealth. No one has as yet devised a satisfactory general national or state plan for the providing of medical care for indigents or those having low incomes.

The conference this year was a valuable one.

SYPHILIS

In joining the campaign to combat the prevalence of syphilis, it is suggested that county societies give consideration to gathering certain essential information as a basis for establishing a campaign program to be conducted under the supervision of members in joint effort with health departments.

*All articles listed under this caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

Diagnostic Facilities

1. Are the services of laboratories ample for "dark-field," blood, and spinal fluid diagnosis?

1a. What recommendations?

2. What clinic facilities are available for treatment of individuals unable to obtain the service of private physicians?

2a. Recommendations as to establishment of such clinics?

3. Are you prepared to transmit to your members a minimum standard of treatment? How?

4. What recommendations as to the holding of clinics for instruction of physicians?

5. How do you propose to educate the lay public?

6. Have you conferred with the local health departments?

6a. Did you arrive at a mutual understanding and agreement?

6b. Did you agree upon fees for services rendered in public clinics?

6c. Did you agree on plan for providing free medication for indigents treated in your office?

6d. Did you agree upon report and record forms.

7. What plans were made for consultation services?

7a. For consultation by specialists?

8. What special problems or difficulties exist due to conditions peculiar to your county?

9. What plans do you recommend for case finding?

10. What plan do you recommend for control of patients who are in the infective stages, and how do you propose to control delinquency?

These are primary fundamentals to be considered and answered by every county society ere their local methods are inaugurated. Assistance and advice will be available through the State Secretary from the following Special State Committee:

Howard Morrow, Chairman, San Francisco.

Charles W. Barnett, San Francisco.

William Henry Goeckerman, Los Angeles.

* * *

The following letters from Surgeon-General Parran are informative.

November 30, 1936.

To the President, California Medical Association.

This will confirm the verbal request which I made to the presidents and secretaries of each state medical society in Chicago on November 16.

I would request that your State Medical Society appoint a committee to advise with your State Health Officer and with me regarding the syphilis control program in each State. Specifically it is my hope that this committee will (a) review the available information on the syphilis problem in the State; (b) cooperate in assembling necessary additional information concerning the nature and extent of the facilities which now exist for the diagnosis, treatment, and public health control of syphilis; and recommend such supplemental and new State and local facilities and measures as seem desirable in dealing with this infection which is nation-wide in its importance and distribution.

As illustrations of the many questions which need careful consideration from the viewpoints of both physician and health officer, I have attached several which will probably come up for discussion during the national conference mentioned below.

Since the Public Health Service is having a national conference on venereal disease control December 20 to 30, it is hoped that I may have a preliminary report from your committee before Christmas in order that the various suggestions which are received can be incorporated in the deliberations of the conference.

Sincerely yours,

(Signed) THOMAS PARRAN,
Surgeon-General.

* * *

QUESTIONS FOR SOLUTION IN SYPHILIS CONTROL

1. The system of notification most suitable to physicians, patients and health agencies.
2. The additional laboratory facilities needed for diagnosis of syphilis.
3. The policy recommended in the distribution of anti-syphilitic drugs.
4. The adequacy of free treatment facilities for those who cannot pay physician's fees.
5. The nature and extent of the additional facilities needed.

6. The physician's part in the application of epidemiologic methods for the control of syphilis.
7. The possibility of developing minimum standards of treatment for early syphilis.
8. The availability of hospital beds for treatment of cases needing hospitalization.
9. Methods for the more adequate prevention of congenital syphilis through recognizing and treating the disease among pregnant women.
10. The lines along which informative and educational programs should be conducted.
11. The possibilities of prophylactic measures being taught and administered through physicians' offices, out-patient hospital services and clinics, with the thoroughness and precautions governing Army and Navy procedures.

TREASURY DEPARTMENT
PUBLIC HEALTH SERVICE
WASHINGTON

December 9, 1936.

Dr. F. C. Warnshuis,
Secretary, California Medical Association,
Four Fifty Sutter,
San Francisco, California.

Dear Doctor Warnshuis:

I thank you for your very kind letter commenting upon my statements at the recent meeting of the Secretaries' Conference in Chicago, and for your offer of cooperation on the behalf of the California Medical Association.

Perhaps I did not make sufficiently clear in my address before the conference in Chicago what I had in mind with respect to recognizing and working through existing agencies in carrying out the expanded public health program which has been made possible under the provisions of the Social Security Act. What I intended to convey was that the Public Health Service will not itself carry on the work within the states, nor will it dictate to the states what the programs shall be or how they shall be conducted. It has been and will continue to be the policy of the Public Health Service to leave largely to the discretion of the several state health authorities the determination of what activities shall be carried on with the federal funds in each state and what methods shall be followed in carrying out such activities.

Social Security funds for assisting the states in public health work are allotted and paid to the state health authorities. The law stipulates that payment may be made only on the basis of plans submitted by the state health authorities. It would, therefore, be impossible for the Public Health Service to enter into any agreement with a state medical society under which such society might become the agency for receiving the funds allotted to the state for conducting the work. Plans for a number of projects have already been submitted by your state health officer, Doctor Dickie, and have been in operation for several months.

However, as I stated in my address in Chicago, the Public Health Service welcomes the cooperation of the state medical societies with their respective state health authorities in studying the health problems and the particular needs of each state, in planning the programs to meet these needs, and in carrying out such measures as may require the participation of the private physician in the actual conduct of the work. I am very much pleased to know that the California Medical Association stands ready to cooperate with Doctor Dickie and, through him, with the Public Health Service, in this great work.

Very sincerely yours,

(Signed) THOMAS PARRAN,
Surgeon-General.

COUNTY SECRETARIES' ANNUAL CONFERENCE

The annual conference of county secretaries, state officers, councilors, and county society presidents will be held at 9 a. m., Saturday, February 6, 1937, in the Sir Francis Drake Hotel in San Francisco.

The following program, Council approved, will govern this conference.

MORNING

9:00-9:10—Opening Statement, Morton R. Gibbons, Chairman of Council.

9:10-9:20—President's Statement, Edward M. Pallette, President.

- 9:20-9:30—President-Elect's Statement, Howard Morrow, President-Elect.
 9:30-10:00—Legislation, Junius B. Harris, Chairman of Legislative Committee.
 10:00-10:30—Hospital and Health Insurance, T. Henshaw Kelly, Chairman of Special Council Committee.
 10:30-11:00—National and State Medical Economic Problems, R. G. Leland, Director American Medical Association Bureau of Medical Economics.
 11:00-12:00—Questions and Answers on above three subjects.
 12:00-1:30 p.m.—Luncheon (Guests of the Council).

AFTERNOON

- 1:30-1:50—Postgraduate Programs, Clarence G. Toland, Chairman of Committee on Postgraduate Work.
 Discussion by Deans of California Medical Colleges.
 1:50-2:10—Public Health Institutes, C. A. Dukes, Chairman of Committee on Public Relations.
 2:10-2:30—Disciplinary Procedure, W. W. Roblee, Speaker of House of Delegates.
 2:30-2:50—County Society Programs, A. E. Varden, San Bernardino.
 2:50-3:10—Malpractice Suits, Hartley F. Peart, Legal Counsel.
 3:10-4:00—Round Table—Questions and Answers.
 4:30—Adjournment.

Secretaries will please send in any particular questions they desire to have answered.

County presidents are invited to be present and are very welcome. The Council regrets that funds are only available to pay the railroad Pullman expenses of secretaries. Should the county secretary be prevented, for good reasons, from attending, the county society is requested to send an accredited alternate, whose expenses will be paid.

Secretaries should make every effort to attend.

MORTON R. GIBBONS, *Chairman.*
 F. C. WARNSHUIS, *Secretary.*

The mutual interchange of experiences, enlightenment as to Association activities, and the presentation of immediate problems, serve to produce better understanding and unity of action. County officers attending these conferences are able to transmit to their local members a truer insight of organizational objectives and endeavors. The ultimate benefit accrues to individual members.

YOUR ADVERTISERS

With the beginning of a new year it is desirable to direct our members' attention to our advertisers. These representative business firms deal with our members and seek to serve them. They advertise in order that our members may know of the type of service they are prepared to render. They seek your business and are desirous of supplying your needs. They approach you through your JOURNAL and pay for that approach. They are your patrons and make your JOURNAL possible by lowering publication costs and thereby lower Association expenses.

For these reasons every member should give first consideration to our advertisers and when in need of supplies to place your orders with these patrons. Give preference to the detail man whose firm is one of our advertisers. Tell the detail man of a non-advertising firm that you have an obligation to patronize your advertisers. In brief, transact business with those who do business with you—your advertisers.

The Council will appreciate your adopting this policy during the coming year. Thanks.

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State medical journals and the *Journal of the American Medical Association* are granted permission to reprint articles and items appearing in each issue.

DUES

The beginning of a new year brings with it the necessity of paying local and state dues for the current year. Lessen the labors of your county secretary by remitting your dues promptly and relieve him of becoming a dunning collecting agent. Send in your check to your county secretary or be prepared to pay him when you go to the next scheduled meeting of your society. Your county secretary will appreciate such consideration from you.

EMPTY SADDLES

Empty saddles in the medical corral—where do we ride tonight?

On entering a new year, vital problems confront us: a state legislature about to convene, expanding federal programs for social security providing medical care, demands for open county hospitals, economists advancing plans for medical care, large employed groups demanding medical and hospital care under some prepayment plan, changing social and business conditions—all these provide reasons for us to pause and find a suitable answer to the figurative question, "Where do we ride tonight?"

The empty saddles of yesteryear's leaders must be filled with competent, capable successors for the tomorrow's rides in order that medicine and its disciples may continue in their quests of research, discovery, and distribution of medical services unmolested or hampered by outside lay or legislative domination. These movements have been under way, gaining momentum for some twenty-five years. They now constitute powerful forces, prone to ignore advice and guidance from qualified representative medical men. For many years physicians, intent upon their professional labors, chose to ignore or give scant attention to the warnings that have been repeatedly uttered. In a more or less desultory manner we stood by while these outside forces advanced on national and state fronts. Reliance was placed in our past records of professional services to fellow men, and consolation was found in our traditions, only to suddenly awaken to the fact that traditions, like treaties, are ruthlessly trod asunder. Advice to organize, to strengthen unity, to cease "resolving" and assume leadership was ignored. Minutes of many meetings contain records of warnings and pleadings, and find these pleadings relegated to files or silenced by negative action. Suddenly we find ourselves at the crossroad that we were eventually bound to come to and there we stand, wondering as to the course to pursue. The chorus swells: "Where—which way do we ride tonight?" The call is for an immediate answer born of the moment, whereas the answer should have been in process of formation these past score of years. We should have been fully prepared to present our answer of solution. As it is, our answer and policy must be formed under the pressure of the emergency. That comprises the immediate pending problem of medicine.

The answer, workable at least and subject to amendments indicated by experience gained as we progress, can be formulated, provided our members exhibit a willingness to act in a spirit of unity. Provided independent members of minority groups will yield to and support the decisions of the majority. There must be no diverging riders in the saddles of medicine.

Our House of Delegates and the Council have appointed committees that are earnestly seeking sound answers and the drafting of sound policies and plans. Confidence should be placed in these saddle-men, who are unselfishly endeavoring to ride for you. They are not lone, independent riders—they are conforming to instructions formulated by the majority, and their plans are approved by the majority before being placed in operation. Trust them. Unity of action and unity of support will bring solution and safety and insure professional security.

SCIENTIFIC EXHIBITS

The Scientific Committee plans to enlarge the scientific exhibits at our annual meeting and cause them to be an outstanding educational feature. Members are requested to file application for assignment of space to the State Secretary on or before April 1, 1937. The exhibits, in so far as possible, will be assembled in groups corresponding to our scientific sections.

In preparing and demonstrating exhibits the following suggestions should be observed:

1. The exhibitor should not attempt to show everything he has collected; the most important items should be selected.

2. Originality is encouraged.

3. Plan space between charts and place them in a horizontal position.

4. Everything should be labeled plainly.

5. Personal demonstration is advised.

In making application for space, submit a seventy-five-word synopsis, explaining the nature and purpose of the exhibit. Indicate the amount of space desired. Applications will be passed on by the Scientific Committee, and applicants will be advised as to acceptance.

DEL MONTE MEETING

It is not too early to remind members that our annual session is to be held in Del Monte the week of May 2. Hotel reservations are coming in in goodly numbers. For hotel accommodations, please refer to page 181, August, 1936, issue.

Please be reminded that *all reservations* for accommodations in hotels in the Monterey area are to be made through Mr. Carl Stanley, Hotel Del Monte, Del Monte. Mr. Stanley is in sole charge of reservations. Write him today stating the accommodations you desire. Do not delay and be disappointed. Write today.

MEETINGS

What meetings shall I attend during 1937? Members will do well to give some thought to this question and plan their work accordingly. The following suggestions are advanced:

1. *My county society.* Why? Because it is your guild. It affords you inestimable opportunities to listen to instructive papers and demonstrations and participate in their discussion. It provides you with an opportunity to be active in committee work calculated to improve professional relations, acquire public good-will, and solve questions that are related to public and professional welfare. It affords regular occasions to make professional contacts, enlarge acquaintanceships, bring about better understanding and cement professional friendships. It enables you to escape being a lone wolf.

2. *Clinics and postgraduate conferences.* Why? In order that you may remain abreast of scientific progress and be capable of rendering the highest type of medical care to your patients. They enable you to remain a "waser" in place of a "hasbeener." They keep you out of professional ruts.

3. *State meeting at Del Monte, May 2-6.* Why? For all the reasons mentioned in 1 and 2. Further, to broaden your viewpoints, to hear and see capable speakers and gain inspiration from them. To visit the scientific and commercial exhibits that are distinctly educational. To learn about state movements and pending questions. To fraternize with your friends and classmates.

4. *American Medical Association in Atlantic City the week of June 7.* Why? For all the reasons aforementioned multiplied upon a national scale. To be a better doctor and public-spirited practitioner and citizen.

Then consider a vacation of at least six weeks. Why? Because everyone needs a change from the routine. Needs to get away to new scenes and environment where he can pursue his own quests, relieved from all professional demands. Vacations enable one to escape those "coronary blocs" and remain hale and hearty at sixty. Plan a vacation, by all means.

If the state of finances permit, now consideration can be given to attending special meetings, clinics, and the taking of a "refresher course" in any of the branches of medicine.

Observing these suggestions will make you a better doctor and bring dividends of contentment and well-being.

"QUIT KICKING SECRETARIES AROUND"

Recently I attended the annual meeting of one of our county societies. The secretary, in making his annual report, stated that he had endeavored to give as much time as possible to his office and sought to serve in his best

capacity. However, he stated, "I do not like to be blamed for everything the Society does or does not do and be accused and made the Society's 'goat.' Possibly there is something wrong with me or the Society."

Such are the rewards of an efficient, zealous county secretary, and such is all too frequently the appreciation for contributed time and effort. There should be a cessation of such lack of appreciation of the services of county secretaries. "Quit kicking them around."

However, a prominent member arose and said, "The trouble with this society is its sixty-five members. Many doctors find that it is less effort to sit on the tuberosities of their ischii than stand on their feet and easier to use their mouths than to think."

Moral: There is need for more effort and unity. More thinking before talking.

OPTIONAL DEFENSE

Upon the payment of \$10 per year, members of this Association can obtain optional legal services from the medical society of the State of California, provided that they carry indemnity insurance with some approved company. Application membership blanks may be obtained from the State Secretary.

This society provides its members with the legal services of an attorney in the event they are threatened or sued for alleged malpractice. That attorney becomes the member's *personal* attorney. He will protect your personal interest, supervise your defense procedures, protect your rights, and join with your insurance company's attorney so as to assure that the provisions of your policy are fully carried out for your protection. Your interests are in his hands and he will assume full direction in all actions, thereby relieving you of these details and worries.

This *personal* legal service is worth many times the amount you pay in annual membership dues in this society. In these days when one out of every twenty doctors will probably become a defendant in a malpractice suit, no practicing physician can afford to be without this personal legal service from a staff of legal experts in medical jurisprudence. Write for membership application.

EXECUTIVE COMMITTEE (Abstract of Minutes)

The December meeting of the Executive Committee was held in San Francisco, December 12. All members were present.

Legislative matters were discussed with the Legislative Committee. Proposed legislation related to hospitals, and medical service insurance was considered and recommendations formulated.

The program for the secretaries' annual conference on February 6 was approved.

The annual budget was reviewed and referred to the Council.

A report from the Committee of Five was reviewed and recommendations were made to the committee.

Social Security program was discussed and committees were appointed.

Dr. Harvey G. McNeil of Los Angeles was appointed secretary of the Section on Industrial Medicine and Surgery to succeed Dr. Mott Arnold, deceased.

Other routine matters were considered and indicated action taken. The session lasted from 9 a. m. to 5 p. m.

F. C. WARSHUIS, *Secretary.*

It is said that among the two billion persons who inhabited this planet during the course of the nineteenth century, not more than one person in a thousand set the slightest imprint upon it. The other 999 left the world just as they found it, without having added one jot or tittle to its stock of knowledge and without having contributed a single idea that was worthy to live. The torch of progress has always been borne aloft by the very few, by those all-too-rare pursuers of the truth whose industry kindles the spark of genius into flame.

The whole fabric of human civilization rests upon the preservation of human life and the increase of human efficiency.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Children's Bureau Welfare Program

During the November conference in Chicago, Miss Katherine F. Lenroot, Chief of the Children's Bureau, Department of Labor, outlined the Bureau's plans regarding maternal welfare and children's medical care. Miss Lenroot stated that the work would be carried on through existing state and local agencies. Not having the opportunity to request a statement as to who constituted "existing agencies" and desiring to learn if perchance "existing agencies" might include lay social organizations, a communication was addressed to Miss Lenroot requesting this information. The urgent suggestion was made that the Bureau recognize the state and county medical organizations as the existing agencies. For our members' information we present the reply to our letter.

UNITED STATES DEPARTMENT OF LABOR
CHILDREN'S BUREAU
WASHINGTON

November 30, 1936.

My dear Doctor Warnshuis:

I appreciate your letter of the 24th with reference to my Chicago address. It was a privilege to have the opportunity of meeting with the group.

As stated in the address, the Children's Bureau welcomes most heartily the coöperation of the state medical societies in the development of the programs for maternal and child health and crippled children. However, the law specifies that we must deal with official state agencies of health. I am enclosing herewith copy of the Act and a copy of our first bulletin explaining its provisions. Coöperation with medical societies, therefore, must be developed through the official state health agencies and we can recognize only such official state health agencies as units to receive funds and be directly responsible for administration. All the funds for local administration go through the state agency. Coöperation of state medical societies has been effected through their representation on state advisory committees and through special services of committees of the state societies. The coöperation of county medical societies is enlisted through the state and local agencies in many aspects of the program.

I note the facilities that would be afforded by the maternal and child welfare standing committees and the sections on pediatrics and orthopedics. I am sure the State Department of Health will welcome such coöperation.

I trust also you will feel free to write me at any time regarding problems which come up and ways in which the coöperative federal-state program may be developed more effectively.

Sincerely yours,

(Signed) KATHERINE F. LENROOT, *Chief.*

Syphilis

To Surgeon-General Parran must go the credit for "blowing off the lid" of American prudery in regard to syphilis. The press, too, has come into the clear and now permits its linotype operators to use the term "syphilis" in place of "social disease." Public ignorance can now be combated, and public as well as professional apathy can be changed to an attitude of combative effort that will gradually reduce the incidence and complications of syphilitic infections.

"The diagnosis and management of syphilis has been written and talked about so much in recent years that there is bound to be trouble ahead for the physician who makes mistakes in diagnoses or who fails to treat the patient properly. Suits for malpractice will follow as rapidly as the public becomes acquainted with what it has a right to expect from the physician."

Professional apathy of physicians in regard to syphilis arises from their lack of fundamental training. For the

physician in practice this lack of fundamental training must be compensated by our county and state societies, editors of medical journals, postgraduate conferences and medical clinics in the providing of competent facilities whereby the practitioner may speedily acquire adequate knowledge. That is an obligation that cannot be ignored. An adequate level of professional competency must be established.

The responsibility of the physician consists of extending himself to attain this level of competency. He dare not neglect doing so because he will pay dearly for his incompetency. The public is becoming informed. This department is receiving an increasing number of inquiries from lay persons seeking information as to where they may obtain dependable information and literature on syphilis. The layman will soon learn whether his physician has been competent in caring for his infection. Our concern is: Will the physician be competent?

The Committee on Public Relations is giving consideration to this subject and hopes at an early date to submit some specific recommendations.

Radio Broadcasts

The American Medical Association is presenting a series of dramatized broadcasts under the title of "Your Health." These valuable educational dramatizations are broadcast over the Blue and Pacific network of the NBC. The program and time is announced in each issue of the *Journal of the American Medical Association*.

If your local station is not broadcasting this program, it is suggested that county medical societies, through designated representatives, interview your station manager and urge that "Your Health" be included in the local programs. This action will be most helpful in bringing dependable information to your community. Tell your patients and friends to listen in at the designated day and hour.

COMPONENT COUNTY MEDICAL SOCIETIES

HUMBOLDT COUNTY

The Humboldt County Medical Society met on the evening of December 3 at the General Hospital, with President J. S. Woolford presiding. Eighteen members were in attendance. The question of hospital insurance and city tax against the physician was widely discussed.

The following officers were elected for 1937: Allan R. Watson, president; Francis Stump, vice-president; Lawrence A. Wing, secretary; John A. Lane, treasurer. Delegate to California Medical Association, G. F. Norman; alternate, J. S. Woolford.

LAWRENCE A. WING, *Secretary.*

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LASSEN-PLUMAS-MODOC COUNTY

A meeting of the Lassen-Plumas-Modoc Medical Society was held in Susanville Friday, November 13, following a banquet at the Grand Café.

Guest speakers were Dr. Phillip Pierson and Mr. Higbee of the California Tuberculosis Association. A plan for the examination of the school children by tuberculosis test and x-ray was outlined and the medical society expressed its approval of such a plan, although it was obvious that many difficulties would be encountered.

Guests included Doctor Cartwright of the United States Indian Service at Fort Bidwell and Doctor Kunkel of the Secret Valley C. C. C. Camp.

FRED J. DAVIS, JR., *Secretary.*

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MARIN COUNTY

At the recent monthly meeting of the Marin County Medical Society, held at the Marin Golf and Country Club, election of officers for the following year was held. The newly elected officers are: Anne C. Brady, president; Scott W. Pollard, vice-president; and Carl W. Clark, secretary-treasurer.

CARL W. CLARK, *Secretary.*

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

PLACER COUNTY

The Placer County Medical Society held its annual meeting in Auburn on Saturday evening, November 7.

The following officers were elected: C. E. Lewis of Auburn, president; William A. Miller of Auburn, vice-president; and Robert A. Peers of Colfax, secretary-treasurer.

Delegate L. W. Empey of Roseville and Alternate Mildred E. Thoren of Weimar were elected last year for a period of two years. Therefore there is no change in delegate and alternate.

ROBERT A. PEERS, *Secretary*.



SAN BERNARDINO COUNTY

The San Bernardino County Medical Society met at the San Bernardino County Charity Hospital on Tuesday, November 10, at 8:15 p. m.

The application for membership of Dr. Kenneth H. Abbott was favorably voted upon. Dr. H. A. Hall's application for transfer from the Los Angeles County Medical Society was voted on and approved.

Dr. F. F. Abbott, chairman of the Committee on Public Relations, reported on the Pioneer Insurance Company. The Pioneer Insurance Company (reorganized G. M. A.) has passed the State Commissioner and is permitted to write life and medical insurance. The medical insurance policy examined by Doctor Abbott is limited in its scope, although the advertising circular states that the policy "pays your hospital and doctor bills."

It was moved by Doctor Clough and seconded by Dr. X. Olsen, that Chapter I, Section 4-e, of the Constitution (regarding the expulsion of a member) be changed to the procedure advised by the California Medical Association, which has been printed in the official bulletin for the past two consecutive months. Passed.

Doctor Mock announced the meeting with the Riverside County Society on January 6, 1937.

The program of the evening was then given as follows:

Case Report—Diagnostic Problem in Splenic Anemia, Dr. Charles A. Wylie and Dr. Arthur E. Varden. Dr. C. C. Owen discussed differential diagnosis of Cooley's anemia and Gaucher's disease from the x-ray pictures.

Mr. Charles A. Son of the Industrial Accident Commission discussed the following points:

1. Compensation. Necessary form should answer the following points: (a) What is the patient's trouble? (b) Did the injury occur while employed?

2. Mr. Son requested a list of men in their respective specialties from which the Commission may select a consultant, etc., in certain cases.

Epileptiform Convulsions: The Newer Methods of Diagnosis and Treatment, Dr. Mark A. Glaser, of Los Angeles.

A. E. VARDEN, *Secretary*.



SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held November 5 in the Medico-Dental clubrooms, in Stockton. The meeting was called to order at 8:15 p. m., President T. C. O'Connor presiding.

The regular meeting was preceded by the customary supper meeting at the Hotel Wolf at 6:30 o'clock, Vice-President John Blinn presiding. Eighteen members were present. Dr. H. S. Chapman spoke on *Sidelights on the Pan-Pacific Surgical Meeting in Honolulu*.

The petitions of Dr. E. A. Anderson and Dr. John T. Heavy for membership in the San Joaquin County Medical Society were read and referred to the Admissions Committee.

Doctor Collis read and submitted a list of donors for blood transfusion from the College of the Pacific. The list was placed on file for future reference.

Nominations for officers for 1937 were as follows: John F. Blinn, president; A. L. Van Meter and A. C. Boehmer, first vice-president; H. W. L. Collis, second vice-president; G. H. Rohrbacher, secretary-treasurer.

Board of Directors—T. C. O'Connor, B. J. Powell, Jr., P. B. Gallegos, Dewey R. Powell, Neill P. Johnson, George H. Sanderson, C. A. Broadus, R. T. McGurk, C. V. Thompson, J. J. Sippy, and N. P. Barbour.

Delegates to State Society—Dewey R. Powell, H. E. Kaplan, J. F. Doughty, and George H. Sanderson. Alternates—M. H. Smyth, C. A. Broadus, and P. B. Gallegos.

The paper of the evening was on *Industrial Medicine and Surgery* by Dr. L. J. Newman. He dwelt on the history of the act and the changes which have come about since 1914.

He emphasized the necessity for clear and prompt reports and explained the importance of details. Compensation is paid entirely on medical evidence, but it is not the policy of the Board to switch patients from one doctor to another, except in the matter of consultation with specialists.

There being no further business the meeting was adjourned, followed by refreshments.



The annual meeting of the San Joaquin County Medical Society was held as a dinner meeting at the new Basque Hotel, 443 South San Joaquin Street, at 7 p. m. Thursday, December 3. In the absence of President Thomas C. O'Connor, Second Vice-President Van Meter presided.

By unanimous consent the reading of the minutes was omitted and the secretary-treasurer's annual report postponed to the next meeting.

The applications of Drs. E. A. Anderson and John T. Heavy, being approved by the Committee on Admissions, were read, and there being no objection from the floor they were declared elected to membership.

The following is the report of Doctor O'Donnell on the annual ballot for the election of officers for 1937: John F. Blinn, president; A. C. Boehmer, first vice-president; H. W. L. Collis, second vice-president; G. H. Rohrbacher, secretary-treasurer.

Board of Directors—T. C. O'Connor, B. J. Powell, Jr., P. B. Gallegos, G. H. Sanderson, C. A. Broadus, C. V. Thompson, and D. R. Powell.

Delegates to State Society—D. R. Powell and G. H. Sanderson.

Alternates—C. A. Broadus and P. B. Gallegos.

Dr. Alex Anderson of Fresno, counselor for our district, was the first speaker of the evening. He presented the matter of *Ethical Advertising* as being carried on in Fresno and recommended that it be more widely used. He recommended the spread of hospital insurance as a buffer for poorhouse medicine, which has never proved successful. He spent further time on the county hospital problem and the impending legislation.

Dr. F. C. Warnshuis, Secretary of the California Medical Association, was the second speaker. He said the problem of the State Association is to keep the individual practitioner abreast of the progress in medicine and to educate the public as to the privileges and advancements of modern medical practice. He spoke further of the medical legislation as it could be expected to develop in our own legislature and in the national congress.

C. A. BROADUS, *Secretary Pro Tem*.



SAN LUIS OBISPO COUNTY

The regular monthly meeting of the San Luis Obispo County Medical Society was held on November 21 in San Luis Obispo. The speaker of the evening was Dr. H. Verrill Findley of Santa Barbara, who presented a paper on the *Injection Treatment of Hernia*, and illustrated the same by means of slides and motion pictures.

The Society decided to request one of the two Council-approved hospital insurance plans, to make arrangements for issuing policies in this county.

E. D. ANDERSON, *Secretary*.



SAN MATEO COUNTY

The meeting of the San Mateo County Medical Society was held in the staff room of the Mills Memorial Hospital at 8 p. m., Doctor Holmes presiding.

The secretary read a letter from the California Medical Association concerning the legal and ethical aspects of the

corporate practice of medicine. Doctor Holmes then introduced Dr. Frederick C. Warnshuis, Secretary of the California Medical Association, who mentioned the fact that the letter had been prepared by the legal staff of the State Association, following the adoption of a resolution at the annual meeting of the House of Delegates of the California Medical Association concerning the corporate practice of medicine.

Dr. Karl Schaupp, chairman of the Executive Committee of the California Medical Association, was next introduced. In connection with the problem of the corporate practice of medicine, he referred to the development of hospital service insurance plans in the State of California and mentioned the fact that certain features of the problem were related to some of the aspects of the problem of hospital service insurance. In discussing the legal aspects of corporate medical practice, Doctor Schaupp stated that the resolution adopted in the Coronado session was not designed to encourage the involvement of every possible case of suspected or proved corporate practice of medicine in a strict analysis of the law. "In those cases where no positive harm accrues it may be advisable," said Doctor Schaupp, "for physicians to wait until they had developed something constructive to offer before attacking such procedures."

Dr. Alfred L. Phillips, councilor for the Fifth District, asked that the problem, as it affected the San Mateo County Medical Society, be more adequately stated.

Doctor Holmes asked the secretary to give a résumé of the situation. It was pointed out by the secretary that certain members of the Society had requested an opinion concerning the practice of medicine by physicians appointed by certain corporations where such practice involved care for sickness and accident complaints of these employees, and in certain instances their dependents, the rate for such services to be dictated by the corporation involved. The secretary expressed the feeling that it was the opinion of some members of the Society that such practices were not in accordance with the principles of professional conduct in that they constituted unfair competition and might well tend to lower the standards of medical practice. Another matter involved in this problem was the question of physicians caring for lodge members at reduced rates. After the elucidation of the problem by the secretary, Doctor Murphy pointed out that another phase of the matter involved the fact that the patient did not have free choice of physician.

Dr. Ralph D. Howe stated that the principle adopted by one of the oil companies did not include care for dependents, and expressed the opinion that in view of the fact that the physician's fee was guaranteed, the doctor should have no objection to providing such care at the reduced schedule.

Doctor Holmes mentioned the fact that after consulting with several employees of one of the oil companies, it was his impression that the employees themselves were not particularly interested in that type of care.

Dr. Howard Mawsley emphasized the fact that free choice of physicians was essential to the practice of medicine, according to recognized standards of professional conduct.

Doctor Schaupp again took the floor and mentioned the fact that one large firm in San Francisco had proposed a similar plan, but after consultation with the San Francisco County Medical Society, decided to cooperate with the doctors and dropped the matter. He stated that competition under such plans is very definitely present and constitutes a very bad feature of such practice. He felt, however, that before any organized group of physicians take action either against a given corporation or against physicians aiding and abetting corporations to follow such plans, a better plan than that offered by said corporations must be advanced, because as long as there is a demand for such service a minority of physicians will be willing to supply them. Doctor Schaupp expressed the opinion that if the organizations of physicians were as closely knit as are most of the trade-unions no difficulty would arise in connection with these problems. He suggested that it might be possible for organized physicians to work out a plan in cooperation with corporations desiring to supply medical service to their employees. A general discussion ensued.

Doctor Warnshuis gave a very helpful and illuminating summary of the problem and proposals for its solution. He reaffirmed the fact that while it was definitely illegal for corporations to practice medicine except where the statute specifically provides for such practice as in the case of the Industrial Accident Commission, owing to many and varied factors, it is impossible to get a district attorney to prosecute corporations involved; and by the same token, where a physician aids and abets a corporation to practice medicine he is breaking that section of the law coming under the Medical Practice Act, and in this instance the Board of Medical Examiners has not seen fit to prosecute the physician in question. Furthermore, there is no denying the fact that from the standpoint of medical ethics such practice constitutes unprofessional conduct. "However, in spite of these principles," stated Doctor Warnshuis, "the answer to the problem is not yet available." Doctor Warnshuis mentioned the fact that the Council of the California Medical Association has proposed to prepare a bill involving the formation of a corporation whose function it will be to present a program whereby in cooperation with certain corporations desiring such services a plan will be inaugurated providing medical service for employees of such corporations. Speaking as the official representative of the State Association, Doctor Warnshuis counseled the county society not to attempt anything radical in regard to the enforcement of the general principles outlined above, but to mark time for a while; at the same time, however, to discourage members of the Society from entering into agreements with corporations which propose to practice medicine. He further stated that the State Association definitely condemned the practice of supplying care for dependents of employees at industrial rates. His final word was that whatever plan might be adopted, its success would depend upon the fact that its operation was in the hands of the physicians.

The secretary then made a motion that the chairman appoint the legislative committee to study this problem and present a resolution embodying the principles outlined by the representatives of the State Association, and to supply an answer to the question concerning the attitude of the San Mateo County Medical Society toward its members who propose joining the medical staff of corporations who desire to secure medical care for their employees at industrial rates. This motion was seconded and carried unanimously.

Doctor Holmes announced that the San Mateo Tuberculosis and Health Association, in connection with its Christmas Seals sale drive, was presenting a radio program over radio station KGO Tuesday evening at eight o'clock, wherein Doctor Murphy was to be interviewed concerning the preventive work anticipated by the San Mateo County Tuberculosis and Health Association and by the San Mateo County Medical Society.

The chairman announced the names of the officers nominated by the Board of Directors for the ensuing year: Doctor Howe, president; Doctor Ray, vice-president; Doctor Bridgman, secretary. Dr. N. D. Morrison was nominated for membership on the Board of Directors. Doctor Holmes called for nominations from the floor, and Dr. H. Hill nominated Doctor Gregory of Redwood City for the presidency. The nomination was seconded by Dr. Jewel Booth Murphy.

J. GARWOOD BRIDGMAN, *Secretary*.



SISKIYOU COUNTY

The last meeting of the Siskiyou County Medical Society for 1936 was held on December 13. The meeting was called to order by the president, Dr. C. C. Dickinson.

A representative of the Intercoast Hospital Insurance Company was to have been present to discuss plans of hospital insurance, but as he was unable to be here this matter was postponed until the next meeting.

Dr. C. C. Dickinson, who is a member of the high school Board of Trustees, stated that the matter of tuberculin testing of all high school children in Siskiyou County had been taken up with the Board and they had approved the idea. The California State Tuberculosis Association is to be notified to that effect. Dr. Albert

Newton of Yreka presented an interesting case of intussusception in an eight-months-old baby boy.

The following officers were elected for 1937: E. F. Carlson of Fort Jones, president; J. T. Steele of Duns-muir, vice-president; J. B. Maguire of Mt. Shasta City, secretary-treasurer; C. C. Dickinson of McCloud, dele-gate; V. W. Hart of Yreka, alternate.

The next meeting of the Society will be held in Yreka on February 14, 1937.

E. F. CARLSON, *Secretary*.

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TULARE COUNTY

The Tulare County Medical Society met in regular meeting at Motley's Café in Visalia on November 15. Dinner preceded the educational program.

Dr. Ottiwell W. Jones, Jr., of the University of Cali-fornia neurosurgical staff, presented a paper on *Head In-juries and Method of Treatment*. Lantern slides were used to clarify and illustrate his talk.

Following the paper a general discussion of neuro-surgical problems were ably answered. The paper was thoroughly appreciated by those in attendance.

Doctor Zumwalt suggested a nominating committee for the coming election of officers, but this was not acted on.

KARL F. WEISS, *Secretary*.

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VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the Ventura County Country Club on Tuesday, October 13, at 7 p. m.

Following the dinner the meeting was called to order by Doctor Shore. Communications from the State Secre-tary's office were read. A short report of the Coronado session was given by the secretary.

Doctor Coffey, Program Chairman, then opened a dis-cussion on the *Feasibility of the San Fernando Plan for Ventura County*. After several minutes of fruitless dis-cussion, it was decided to postpone the matter. None of the proponents of the plan were present.

Doctor Coffey introduced Doctor Homer of Ventura, who presented an interesting paper on *Gall-Bladder Dis-eases*. Doctor Shore opened the discussion.

A. A. MORRISON, *Secretary*.

CHANGES IN MEMBERSHIP

New Members (15)

Alameda County.—Floyd I. Hohnstein.

San Diego County.—Ruth H. Hubbert, Arthur A. Mar-low, John B. Minna, Arthur D. Tuttle.

San Francisco County.—Elmer C. Bricca, E. Francis Egleston, Philip K. Gilman, Jr., John J. Hopkins, Sophie M. Loven, Joseph S. McGuinness, J. Maurice Robinson, Jerome F. Zobel.

Yolo-Colusa-Glenn County.—Edwin K. Copeland, John B. Hollingsworth.

Transferred (8)

Fred J. Crease, from Los Angeles County to Kern County.

Clarendon A. Foster, from Los Angeles County to Monterey County.

Horace A. Hall, from Los Angeles County to San Ber-nardino County.

H. M. Hawkins, from Los Angeles County to Kern County.

Lester Jankay, from Los Angeles County to Santa Bar-bara County.

Roderick A. Ogden, from Los Angeles County to San Francisco County.

William H. Wimp, from Los Angeles County to Orange County.

J. Guild Wood, from Los Angeles County to Oklahoma.

Resigned (1)

H. Ross Magee, from Los Angeles County.

In Memoriam

Arnold, Mott Hunton. Died at San Diego, December 9, 1936, age 53. Graduate of the University of Illinois College of Medicine, Chicago, 1907. Licensed in Cali-fornia in 1915. Doctor Arnold was a member of the San Diego County Medical Society, the California Medical Association, and the American Medical Association.

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Ball, Jau Don. Died at San Francisco, November 25, 1936, age 56. Graduate of the University of Virginia De-partment of Medicine, Charlottesville, 1902, and licensed in California the same year. Doctor Ball was a member of the San Francisco County Medical Society, the Cali-fornia Medical Association, and a Fellow of the American Medical Association.

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Bigby, Margaret Helen. Died at Whittier, September 26, 1936, age 49. Graduate of the University of Michigan Medical School, Ann Arbor, 1917. Licensed in California in 1919. Doctor Bigby was a member of the Los Ange-les County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Hemken, Louisa. Died at Los Angeles, November 20, 1936, age 32. Graduate of Rush Medical College of the University of Chicago, 1929. Licensed in California in 1930. Doctor Hemken was a member of the Los Ange-les County Medical Association, the California Medical Association, and a Fellow of the American Medical As-sociation.

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Hieronimus, Arthur. Died at Alameda, December 5, 1936, age 65. Graduate of Bellevue Hospital Medical Col-lege, New York, 1897. Licensed in California in 1902. Doctor Hieronimus was a member of the Alameda County Medical Association, the California Medical As-sociation, and a Fellow of the American Medical As-sociation.

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Kendall, Oscar J. Died at San Diego, November 18, 1936, age 77. Graduate of Tulane University of Louisiana School of Medicine, New Orleans, 1884. Licensed in Cali-fornia in 1899. Doctor Kendall was a member of the San Diego County Medical Society, the California Medi-cal Association, and a Fellow of the American Medical Association.

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Lund, Charles Walter. Died at Willows, November 4, 1936, age 60. Graduate of the College of Physicians and Surgeons, San Francisco, 1903, and licensed in Cali-fornia the same year. Doctor Lund was a member of the Yolo-Colusa-Glenn County Medical Society, the Cali-fornia Medical Association, and the American Medical Association.

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Witherbee, Orville O. Died at Los Angeles, De-cember 24, 1936, age 70. Graduate of the Northwestern University Medical School, Chicago, Illinois, 1893, and licensed in California the same year. Doctor Witherbee was a member of the Los Angeles County Medical As-sociation, the California Medical Association, and a Fellow of the American Medical Association.

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Woods, Donald Kendrick. Died at San Diego, De-cember 10, 1936, age 46. Graduate of Rush Medical Col-lege, University of Chicago, 1913. Licensed in California in 1924. Doctor Woods was a member of the San Diego County Medical Society, the California Medical Associ-ation, and a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

News Letter

December 12, 1936.

Dear Auxiliary Members:

There are several things to be brought to your attention, and I think the new year is a good time to do this:

The Doane Trophy. This trophy was donated by Mrs. Philip Schuyler Doane to be given to the Auxiliary obtaining the largest number of new members during the year. This does not necessarily mean that only the large auxiliaries can compete for the trophy; if the small auxiliaries can get their membership up to or approximating 100 per cent, they will be considered when the award is to be made. It is up to every member to do her part to induce all who are eligible to join and help her auxiliary win the coveted trophy.

The National News Letter. This is issued four times a year by the National Auxiliary. To quote Mrs. Fitzgerald, our president: "The object of the News Letter is to pass from one group to another, news of interest and suggestions for new activity. This interchange of ideas and information is stimulating because from it evolves a feeling of friendliness between the different sections of the country—a feeling of friendliness which comes from the realization of our common problems. The News Letter cannot, of course, be valuable from the standpoint of literature, but it can be valuable as a distributor of news. You can contribute to its value and usefulness by sending in bits of news you think might be of interest to others." The subscription price is \$1 a year, and each county publicity chairman would benefit by reading the News Sheet.

Hygeia. Have you sent in your subscription to *Hygeia*? You all know what the magazine stands for and how interesting it is. Please do not forget to renew your subscription now and try to get a new subscriber as well.

The Courier. This, our semiannual newspaper, has been published, and every Auxiliary member had a copy mailed to her. If you did not receive any, please notify me and I will attend to it immediately.

Very best wishes for a Happy and Prosperous New Year.

Sincerely yours,

MRS. ROBERT M. FURLONG,
Press and Publicity Chairman.

* * *

Component Auxiliaries

Alameda County

The Woman's Auxiliary to the Alameda County Medical Association, with eighty members and guests present, met on Friday, November 20, at the Claremont Country Club, Oakland.

Mrs. Thomas J. Clark, as the reception chairman, received members in the lobby of the Club for a social half-hour before convening for luncheon. The tables were festively decorated with red berries of the season.

Following the luncheon, Dr. W. E. Mitchell gave a most inspiring talk on *The Romance of Medicine*. He followed the advance of medicine from its crude beginnings down to the present day. He took us back to ancient Greece to Hippocrates, who is said to be the first man to have given modern thoughts to medicine, and to have contradicted the old belief that disease in a patient was supernatural.

Doctor Mitchell stressed the point that the downfall of ancient civilizations was moral degeneration due to the

ravages of war and disease, and brought about through the lack of medicine and surgery.

But it was not until the tenth century that the first medical school was established in Salerno. In the fifteenth century, a ban was put on the study of anatomy. But this did not stop the study of those men who were hungering for knowledge. Later the church came to their rescue, and from then on the advance of science moved steadily on.

Doctor Mitchell gave a short résumé of the lives of some of the great men who contributed so largely to the advance of medicine and surgery, such as Galen, Morton, Pasteur, and Lister. He also said in part that enough cannot be said of the great work done by the public health departments of this country. It was through their efforts and investigation that typhoid fever, yellow fever, and bubonic plague have been brought under control.

Doctor Mitchell accompanied his talk with slides illustrating his subject-matter.

In closing, he said that in spite of the great strides made in the last few years in medicine, surgery and scientific research, he felt that there were still much greater things ahead of us, and that it was especially important that interest in the scientific approach of problems be kept alive in the minds of the public of today.

A short business meeting followed, conducted by Mrs. Clarence Page, after which the meeting adjourned until January.

MRS. JOHN OHANNESON.

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Orange County

Beautiful Christmas music made up the program for the musicale tea to which members of the Woman's Auxiliary to the Orange County Medical Association invited guests Tuesday afternoon in the Ebell Clubhouse lounge. Forty members and visitors made up the gathering.

Dispensing with business in short order, Mrs. K. H. Sutherland, president of the group, introduced two out-of-town visitors—Mrs. B. H. Sherman, councilor of the Los Angeles district auxiliary to the California Medical Association, and Mrs. A. Downs of the Los Angeles auxiliary—and welcomed the other guests who were sharing the afternoon with the members.

The meeting was then turned over to the Program Committee, who presented three talented guest artists—a boy soprano, harpist, and vocalist.

Duncan McCleod, youngest of the artists, opened the program with three Christmas numbers—"Adeste Fidelis," "Alleluia" by Mozart, and "Ave Maria" by Schubert. He was accompanied by his mother, and in the last also by Miss Regina Wahlberg of Fullerton, harpist.

His second group, given in Scotch costume and the McCleod clan plaid, included "Lassie o' Mine," "One Hundred Pipers," and "Safest o' the Family."

Miss Wahlberg, a talented harpist, played three numbers—"My Heart at Thy Sweet Voice" from "Samson and Delilah," "Volga Boatman," and "Trees."

Mrs. E. Wagner of Santa Ana, the third artist, sang three lovely soprano numbers—"Habanera" from "Carmen" by Bizet; "There Is a Garden" by Proctor, and "Ecstasy" by Rummel. All of the numbers were delightful and the three musicians received much applause.

During the social hour following, Mrs. H. D. Newkirk of Anaheim and her committee of doctors' wives from that city served a dainty tea collation, spreading their table with a pretty cloth which Mrs. H. A. Johnston brought from Italy. Red and gold appointments and flowers were used on the table, and those assisting Mrs. Newkirk were the Mesdames Johnston, George Paige, C. A. Neighbors, K. G. Parks, John Woods, and E. H. Kersten.

This will be the last meeting of the Auxiliary until February, Mrs. Sutherland announced.

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Los Angeles County

Sounding the modern note of coöperation between organized groups, the Woman's Auxiliary to the Los Angeles County Medical Association has perfected a plan to work with the health departments of the Parent Teacher Association of the city and county.

† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Robert M. Furlong, chairman of the Publicity and Publications Committee, Linden Lane, San Rafael. Brief reports of county auxiliary meetings will be welcomed by Mrs. Furlong and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

The plan was presented at the luncheon November 24 at the County Medical Building, with 110 members present and sixteen leaders of the Parent-Teacher Association as special guests.

The Auxiliary is offering two prizes to the Parent-Teacher groups doing the best health education work during the coming year. Twenty subscriptions to *Hygeia* will be given to the winning group in both the city and county districts.

After the presentation of the plan, a very stirring talk was given by Dr. Herbert Anderson on *Abundant Health*, followed by Mrs. E. B. Plimpton in a short paper on *Nobel Awards in Medicine*.

Another distinguished guest was Dr. Edward M. Pallette, president of the State Medical Association, and member of the advisory board of the State Congress of Parents and Teachers, who warmly commended the movement of the Auxiliary to work in coöperation with the Parent-Teacher Association, declaring that "The Parent-Teachers reach the public with their program, and the Woman's Auxiliary is in a position to furnish authoritative information on health questions."

MRS. ROBERT L. CARROLL.

Health Education Project

The National Education Association gives health first place among the seven objectives of education. The object of the Health Education Project of the Woman's Auxiliary to the Los Angeles County Medical Association is to help parents and children to appreciate the difference between potentially harmful health fads and basic health facts.

Believing that better health conditions will follow wider and more complete dissemination of basic health facts among parents and children, through active participation with health chairmen of local Parent-Teacher Associations in an organized better health program, the Woman's Auxiliary to the Los Angeles County Medical Association will offer prizes to the health committee judged to have made highest scores in the better health activities listed on the accompanying sheet.

Prizes will be awarded as follows:

1. Twenty one-year subscriptions to *Hygeia*, to be given to the two associations in First District Parent-Teacher Association judged by the committee to have attained the highest record of achievement in a better health program.
2. Twenty one-year subscriptions to *Hygeia*, to be given to the two associations in Tenth District Parent-Teacher Association judged by the committee to have attained the highest record of achievement in a better health program.

Study envelopes, containing articles on subjects pertaining to health, such as communicable disease control, prevention of blindness, milk, and the physically handicapped, are available free to those participating in this project. Health plays, suitable for children or adults, for the entertainment feature of a health program are also available. A Speakers' Bureau, offering speakers on a wide variety of health subjects, will provide speakers for your programs if you will call at least two weeks in advance.

Rules of Contest

1. Application blank signifying intention of local Parent-Teacher Association participation, must be filed with the Woman's Auxiliary to the Los Angeles County Medical Association by February 1, 1937.
2. Report of activities on blank provided must be filed in the Auxiliary office by May 1, 1937.
3. Submitted contest data will be judged by a Committee on Awards, composed of two members from the Auxiliary, one from First District Parent-Teacher Association, one from Tenth District Parent-Teacher Association, and one from the School Health Department.

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Marin County

The Woman's Auxiliary to the Marin County Medical Society held its regular monthly dinner meeting at the Marin Golf and Country Club, San Rafael, on Thursday evening, November 19, 1936.

Mrs. T. Gocher, chairman of *Hygeia*, opened her *Hygeia* drive by asking each member to obtain at least two subscriptions before our next meeting in January.

Copies of the constitution of the Marin County Auxiliary were distributed among the members present. It was decided that our auxiliary should subscribe to the National News Letter for our president.

Plans for a bridge party to be given the latter part of January, to augment the fund in our treasury, were left in the hands of the Entertainment Committee.

Following the dinner and business meeting, Dr. Bernard Kaufman of San Francisco gave a most interesting talk, illustrated by motion pictures, on *The Relation of Palestine to the Mediterranean Problem*. It was a comprehensive account of the political situation in the Mediterranean, with particular reference to the Palestine section, its natural resources, and the amazing growth of the reforested area surrounding the city, as well as the remarkable growth of Palestine.

BERDELLA M. ROBERTSON, *Publicity Chairman*.

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Sacramento County

The Woman's Auxiliary to the Sacramento Society for Medical Improvement met in Sacramento on November 17, 1936, at which time the reports of the various activities of the Society were read.

The tuberculosis test in the Main High School reported 28 per cent were positive. The work was very interesting, and the ladies who assisted were: Mesdames York, Cook, Norris Jones, Scatena, Sontar, Hipp, Pitts, Millar, and Brown. Motion pictures were taken of the whole procedure. Other members have been busy folding tuberculosis seals, folding envelopes, under the direction of Mesdames Walter Hicks, Vaniva, Krull, George Spencer, Sontar, Kammer, and H. J. Davis. The Red Cross drive was under the direction of Mrs. Orrin Cook.

Mr. Leo Baisden, assistant superintendent of schools, spoke on *The Rehabilitation of the Crippled Children of Sacramento*. Mrs. Donald Benson, accompanied by Miss Isobel Taylor, was the guest soloist. Hostesses were Mesdames George Spencer, Paul Grittman, J. D. Coyle, G. E. Millar, George Walsh, H. H. Beauchamp, H. J. Davis, and Louis Jones.

The Sacramento Woman's Auxiliary will aid in giving the tuberculosis test to parochial schools December 14 to 16. The Christmas meeting will be held in the home of the junior past president, Mrs. Scatena, where the festivities will be full of Christmas spirit, exchange of gifts, bridge with prizes, Christmas music and carols.

Plans are being formulated for a dinner dance late in January. Mrs. Solomon N. Weil, state president-elect, will be the honored guest.

MRS. JOHN D. LAWSON, *Secretary*.

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Santa Barbara County

In November the Woman's Auxiliary to the Santa Barbara County Medical Society held a membership tea at the home of Dr. and Mrs. Henry J. Ullmann. Doctor Ullmann is one of the district councilors of the California Medical Association, and Mrs. Ullmann graciously sent out invitations to the wives, mothers, and adult daughters of all the doctors in the county. Mrs. William R. Hunt, president, Mrs. Frank Hombach, Membership Chairman, and Mrs. Horace Coshaw, Hospitality Chairman, assisted with the arrangements. The past presidents, wearing corsages of pink sweet peas, were in the receiving line. Delightful music was furnished by a string trio. About sixty ladies enjoyed Mrs. Ullmann's gracious hospitality and the beauty of her hilltop home. Mrs. Hombach expects to add ten or twelve new names to the membership list as a result of the tea.

The December meeting of the Santa Barbara group was in compliment to Mrs. Andrew J. Thornton. On the second of the month she made a special trip from her home in San Diego to visit Santa Barbara, and was entertained at breakfast at El Encanto Hotel. Afterward she spoke to us informally of her visits to other county society auxiliaries, and our members plied her with questions until the hour grew late. After a short ride around the city, Mrs. Thornton and several of the members of the Auxiliary attended the luncheon meeting of the Health Section of the County Council of Social Agencies. Mrs. Thornton returned to San Diego that afternoon by airplane, but her inspiration and helpful suggestions remain to help us with our work.

ELISABETTA HENDERSON, *Reporter*.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 7-11, 1937. Olin West, M. D., 535 North Dearborn Street, Chicago, secretary.

California Medical Association, Del Monte, May 3-6, 1937. F. C. Warnhuis, M. D., 450 Sutter Street, San Francisco, secretary.

Western Section: American Laryngological, Rhinological, and Otolological Society, San Diego, January 30-31, 1937. Dr. David R. Higbee, 3245 Fourth Avenue, San Diego, chairman.

Medical Broadcasts*

American Medical Association

The American Medical Association and the National Broadcasting Company are presenting the second series of dramatized health broadcasts, under the title "Your Health." The first broadcast in the new series, the thirty-second dramatized cooperative broadcast under the title "Your Health," was given October 13. The theme for 1936-1937 differs slightly from the topic in the first series, which was "Medical Emergencies and How They Are Met." The new series is built around the central idea that "one hundred thousand American physicians in great cities and tiny villages, who are members of the American Medical Association and of county and state medical societies, stand ready, day and night, to serve the American people in sickness and in health."

The program will be on the Blue network instead of the Red, as originally announced.

The topics are announced monthly in advance in *Hygeia*, the health magazine, and three weeks in advance in each issue of the *Journal of the American Medical Association*.

The time of the broadcast is Tuesday afternoon, two o'clock, Pacific time.

San Francisco County Medical Society

A radio broadcast program for the San Francisco County Medical Society for the month of January is as follows:

Tuesday, January 5—KYA, 6 p. m.
Tuesday, January 12—KYA, 6 p. m.
Tuesday, January 19—KYA, 6 p. m.
Tuesday, January 26—KYA, 6 p. m.

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of January is as follows:

Saturday, January 2—KFI, 9:15 a. m.
Saturday, January 2—KFAC, 10:15 a. m.
Tuesday, January 5—KECA, 10:30 a. m.
Saturday, January 9—KFI, 9:15 a. m.
Saturday, January 9—KFAC, 10:15 a. m.
Tuesday, January 12—KECA, 10:30 a. m.
Saturday, January 16—KFI, 9:15 a. m.
Saturday, January 16—KFAC, 10:15 a. m.
Tuesday, January 19—KECA, 10:30 a. m.
Saturday, January 23—KFI, 9:15 a. m.
Saturday, January 23—KFAC, 10:15 a. m.
Tuesday, January 26—KECA, 10:30 a. m.
Saturday, January 30—KFI, 9:15 a. m.
Saturday, January 30—KFAC, 10:15 a. m.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Symposium on Heart Disease.—The postgraduate symposium on heart disease, given at San Francisco on November 18 and 19, the program of which was printed on page 442 of the November issue, recorded an attendance of California physicians representing some fifty cities.

The new officers of the Heart Committee elected for the year 1937 are as follows: John P. Strickler, M. D., chairman; William Dock, M. D., vice-chairman; and Elbridge J. Best, M. D., secretary.

Indo-Latin College of Surgeons.—A new organization, the Indo-Latin College of Surgeons, was founded in Mexico City November 20, 1936, during the meeting of the Second National Assembly of Surgeons of Mexico. It will be comprised of a membership from Mexico, Central and South America, and be patterned after similar organizations in this country, Canada, and England. The venerable Dr. Ulises Valdéz of Mexico City was chosen the first president.

At the present time a few of the Mexican surgeons are members of the American College, but it is quite apparent that due to the difference in language, customs, and nationalistic spirit of the Spanish-speaking countries, they should have their own organization. The percentage of Mexican physicians speaking English is certainly not greater than that of the American physicians speaking Spanish, and does not exceed five per cent.

Dr. Felix Miller of El Paso and Dr. Carl Hoag of San Francisco were the official representatives of the American College of Surgeons at the founding ceremonies.

School Absences and Disease Reporting.—School appropriations in California are based upon average annual attendance, with proper allowances for absences due to epidemics. Because of the wide variation in the methods employed in reporting epidemics, it has become necessary for the State Department of Public Health to adopt a uniform procedure. Following is the text of a letter upon this subject sent recently to all local health officers in the State by Dr. Walter M. Dickie, Director of Public Health:

To preserve the purpose of reporting those diseases designated by law and to insure accuracy in our statistical procedure, it has become necessary to make some changes in the method of submitting the records of those cases not attended by physicians.

Therefore, beginning with this school year, we shall refuse to accept any reports of cases of communicable diseases unless submitted to us in the regular way—that is, through the local health officer at the time the illness occurs and on the official cards provided for that purpose.

Our experience during recent years has been very unsatisfactory with reference to the procedure for reporting communicable diseases in school children. At the end of the school year, the school authorities have stressed the point of having all cases of the diseases epidemic during the school year reported, to enable us to certify to the State Department of Education that epidemic conditions did exist and thereby permit them to request emergency attendance consideration. In many instances to complete our records, the school principal or the superintendent sent us lists of children's names as cases.

These cases not attended by physicians must be reported by the parents, the nurse, or the school authorities either at the time of the illness, or when the child returns to school, these reports to be submitted to you as health officer and if acceptable to you they shall be forwarded to the State Department of Public Health.

Lists of names prepared by school authorities at the end of the school year will not be accepted. We ask that you convey this information to the school superintendents and principals in your territory.

Rheumatic Disease in Northern California.—A hint that the people of northern California should take extra precautions to guard their health during December, January, and February, to help prevent or overcome rheumatic diseases, is contained in a report by Dr. Amos Christie, instructor in pediatrics and medicine in the University of California Medical School. At the same time, Doctor Christie states, "we are dealing with a benign type of rheumatic infection, comparable with that of other communicable diseases in California."

The study made by Doctor Christie revealed "an unusually high hospital incidence and a low general incidence" of rheumatic fever in northern California. A study of 116 cases in San Francisco indicates that the incidence of carditis, or inflammation of the heart, in combination with other rheumatic manifestations, is correspondingly low.

The high hospital incidence of rheumatic disease in San Francisco is strikingly in contrast with the low general incidence, according to Doctor Christie. One reason advanced is that many persons migrate to California for their health and seek the hospitals of the big cities for the treatment of rheumatic ailments, but this reason is not fully borne out by the showing made by hospitals in other populous centers of the State. The low incidence of rheumatic fever among school children in San Francisco may also be attributed to the possibility that the disease becomes benign for long periods after its typical onset, although this is also a matter of considerable speculation.

But the fact remains, according to Doctor Christie, that in San Francisco "we deal with a relatively benign type of rheumatic infection, when measured in terms of cardiac damage resulting from the rheumatic infection."

Doctor Christie's report appears in the current issue of *The American Heart Journal*.

Too Much Sunshine, Bottled or Free, Declared Serious.—The absorption of California's widely advertised sunshine, either externally or internally, should be in moderation or serious results may follow. External consumption is represented by the sun bath and various other forms of irradiation in which either Old Sol himself figures, or his place is taken by a lamp or other contrivance. Internal consumption is represented by the vitamin D concentrates and preparations sold by drug stores or added to foods. This is the famous "sunshine vitamin."

The University of California Medical School and the San Francisco Department of Public Health have joined in a warning against too much sunshine, particularly in the concentrated form, because of the possibility of delayed harmful effects. The University's warning reads:

"Naturally this is not an argument for interfering with the treatment or prevention of rickets by vitamin D. But it is a plea to use some discretion in the amounts of vitamin D prescribed. Commercial enterprise is endeavoring to capitalize to the fullest in the current popular vogue for vitamin D. In addition to a sun-tan craze there are ballyhooed everywhere irradiated foodstuffs of all varieties, metabolized milks and even 'sunshine soaps.' But when on top of an unknown but probably quite adequate intake of vitamin D, especially in Sunny California, children are dosed with large amounts of vitamin D preparations by overanxious mothers, it is time for physicians to use care in prescribing the drug."

The warning of the San Francisco health department states:

"The director of public health wishes to record the fact that he disapproves of the present tendency of manufacturers to add measured quantities of vitamins to foods for commercial purposes. There is still considerable question, particularly in the instance of vitamin D, of what constitutes the proper dosage of vitamin concentrates in the various age groups. Any attempt to increase the sale of a food product, especially milk, by the addition of a substance whose value to the public health is still a controversial problem is indeed ill-advised. Even if it is granted that the actual danger in the consumption of vitamin D milk is relatively minimal, there is as yet no definite and accepted information on the limits or margins of clinical safety."

The University's statement was prepared by Dr. Chauncey D. Leake, professor of pharmacology, and the city's statement by Dr. J. C. Geiger, health officer.

Stanford Popular Medical Lectures.—The Stanford University School of Medicine, San Francisco, announces the fifty-fifth series of popular medical lectures to be given in Lane Hall on alternate Friday evenings at eight o'clock during the winter quarter, 1937. The dates, titles, and lecturers are as follows:

January 8—Syphilis and Its Control, Dr. Jacques P. Gray.

January 22—The County Hospital and the Public, Dr. Benjamin W. Black.

February 5—Recent Advances in the Treatment of Tuberculosis, Dr. William C. Voorsanger.

February 19—The Crippled Child, Dr. Frederic C. Bost.

March 5—Behind the Scenes of Pain Relievers in Dentistry, Dr. Sanford M. Moose.

March 19—The Rising Death Rate From Heart Disease, Dr. J. Marion Read.

Undulant Fever Symposium.—Following is the program of an undulant fever symposium recently held under the auspices of the Southern California Public Health Association and the Internal Section of the Los Angeles County Medical Society at the Los Angeles County Medical Association Building, Wilshire and Westlake avenues, Los Angeles:

General Discussion of the Problem—Dr. Karl F. Meyer, Director of the George Williams Hooper Foundation for Medical Research, San Francisco.

Public Health Problems—Dr. Wilton L. Halverson, Health Officer, Pasadena.

Laboratory Problems—Dr. Alvin G. Foord, Pathologist, Huntington Memorial Hospital.

Medical Problems—Dr. Philips J. Edson, Pasadena.

Dr. R. V. Stone of the Los Angeles County Health Department is president and Mr. Charles W. Arthur of the Pasadena City Health Department is secretary of the Southern California Public Health Association.

Cervix Cancer Can Be Sharply Reduced.—If it were possible to examine a large number of women at intervals through the simple procedure of an iodine stain, now perfected, the present high mortality from cancer of the cervix or neck of the womb would be greatly reduced. A nearly 100 per cent security for permanent definite healing is possible where the cancer or carcinoma of this type has been detected at the very beginning of its onset by means of the stain. Diagnosis of cancer of the cervix is now possible through the stain, long before the tissue change becomes apparent to the patient or possibly to the doctor himself.

These findings were detailed to the faculty of the University of California Medical School by Dr. Walter Schiller, noted pathologist of the Frauenklinik, Vienna, in a recent visit to the school. Doctor Schiller likewise detailed the long years of tedious laboratory and clinical study before the stain process could be determined or proved. He is credited with being the discoverer of the process.

"The genuine early cancers consist of a superficial layer, first without and then with cones penetrating deeply," he said. "Therefore all early growths have a smooth surface, the superficial layer lying quite flush with the normal surface and showing no papillary (nipple-like) growth, recesses or ulceration. This is what makes it so difficult to diagnose the first stage of cancer, because the superficial layer is not distinguished either in color or form from the normal surrounding epithelium."

Cancer of the cervix usually starts when the glycogen, a carbohydrate found in most of the actively functioning cells of the body, disappears from the superficial tissue. This change occurs suddenly and without intermediate stages; but it can be detected by the aqueous iodine test, which marks off the areas which contain no glycogen. This carbohydrate is always absent in cancer. If the cervix is washed with the iodine solution, normal epithelium will become stained dark brown within twenty or thirty seconds, while cancerous epithelium will remain white.

The optimal solution was also described by Doctor Schiller as pure iodine, one part; potassium iodide, two parts; water, 300 parts. The method can be applied without difficulty, with no discomfort to the patient, and quickly produces the desired showing.

Safety Nets on Golden Gate Bridge.—On July 13, 1936, the California Industrial Accident Commission held a hearing with the contractors on the steel-erection work for the suspension span of the Golden Gate Bridge, San Francisco. Following this hearing the Commission ordered nets installed for the protection of all workers who might fall during the steel erection, painting, paving, and electrical work.

In complying with this order the contractors, in coöperation with the Golden Gate Bridge and Highway District, constructed nets 120 feet wide and totaling over 6,400 feet long, extending from the concrete pylon on the San Francisco side to the corresponding pylon on the Marin side, and 10 feet beyond each side of the bridge work. The work of hanging the nets was done from four net travelers, thus providing 100 per cent protection to all workmen once the net travelers were erected.

To date, three lives have positively been saved because these men fell into the net, and without this protection would have fallen into the bay, 200 feet below.

This net is an innovation in safety on bridge construction, and due to its success not only as to safety, but because it has speeded up erection work, will, no doubt, establish a standard that will be used on future bridges.

Already the Industrial Commission of British Columbia has made inquiries into the practicabilities and cost of this net, and they will no doubt install such a net on the bridge across the narrows at Vancouver.

It is hoped all future bridges will require some form of safety net.

The Cancer Clinic in Medical and Dental Schools.—Grant E. Ward, M. D., in the December Bulletin of the American Society for the Control of Cancer, states:

"Since 1900 vital statistics in various large centers of population and in all registration districts throughout the United States have shown a steady rise in cancer mortality, until, at present, cancer is second only to cardiovascular diseases as the cause of death. (Some statistics place pneumonia second and cancer third.) The question naturally arises, 'Why the increase in cancer deaths and is it real or apparent?' Several facts come to the fore in the study of this question.

"In the last fifty years, advances in scientific medicine have changed the order of death dealing diseases. A half-century ago communicable diseases—plague, smallpox, diphtheria, typhoid, infant dysentery, malaria, yellow fever, tuberculosis—were the great scourges of the civilized world. One by one these epidemics have been conquered. The 'white plague,' which at one time led in the cause of death, is now far down the list. . . . Most of these infectious diseases took their toll of death from infants, children and young adults, so that the average age of our population about forty or fifty years ago was about thirty-five. As infectious diseases were controlled, the average age of man has gradually increased, until today it is fifty years or more. This means that people living through the average age of fifty will die of diseases occurring in the latter years of life. One of the chief of these is cancer. Cancer is recognized as a disease of middle and late life, although we are continually seeing cancer in the younger ages. Cardiovascular diseases, nephritis, and the like, are also diseases of later life and are now prominent in the cause of death as compared with a few decades ago, even ahead of cancer.

"According to the statistics of the New York Health Department, there is not an actual increase in the percentage of death caused by cancer in the various age groups.

"This report charts the cancer deaths for the various decades of life, including the years ten to eighty. Although many more persons live to the upper decades of life (above forty) than formerly, the percentage of deaths from cancer in the upper brackets is no larger than it was in 1900.

"Other factors bearing on the increase in cancer deaths throughout the country are more accurate vital statistics, correct diagnosis by x-rays, pathologic studies, and more exact diagnoses by operation.

"Interpret these data as one will, cancer is second in the toll of death throughout the country. This means that it is of paramount importance to teach medical and dental students the early symptoms of cancer and to make them 'cancer-conscious,' so that they will recognize all types of pre-malignant diseases during routine examinations." . . .

New Blood-Clot Factor Found in University of California Laboratory.—Discovery of an additional factor in the mechanism of blood clotting in humans and animals is reported from the division of biochemistry, University of California. The laboratories concerned are now trying to isolate this factor and to determine its chemical nature.

The possibility that when this work is cleared up it may play a part in the treatment of certain diseases in which abnormal bleeding is present, is expressed by the discoverers. Among these diseases are hemophilia, and hemorrhages arising from jaundiced or other conditions.

Notification of the discovery was published by Dr. David M. Greenberg of the division of biochemistry, and Clarence E. Larson, graduate student, formerly in the division and now in the laboratories of the Mount Zion Hospital, San Francisco.

Story of the Christmas Seal.—Einar Holbell, a postal clerk in Copenhagen, wanted to build a hospital for tuberculous children. As he sorted stacks of letters at Christmas time, his thoughts flashed back and forth between the cheer of holiday mail and the tears of children. From the postage stamps of his beloved Denmark on the front of mail, he conceived other colorful stickers on the back, each to be sold for a penny, the funds so derived to fight tuberculosis, greatest killer of all times.

Appealing to his king and queen, Holboell received royal approval, and thus, in 1904, was born the Christmas Seal, an idea so compelling that it has encircled the world, a mighty force for the prevention of needless deaths.

In 1907, Miss Emily Bissell of Delaware, who also wanted to build a hospital for tuberculous children, learned of the Danish Christmas Seals. She published and sold the first American Seals that year. Then the Tuberculosis Association adopted the plan, and today the aggregate of funds thus raised has reached \$80,000,000.

Silicosis in California.—The State Assembly Committee, authorized by the Legislature to investigate the problem of silicosis, met in the State Building, San Francisco, on Tuesday, November 10.

Commissioner Frank C. MacDonald reported to the committee concerning the law and the safety program inaugurated under his supervision for the purpose of protecting employees in California from hazardous exposure to dusts, fumes, vapors, and gases.

Mr. Daniel W. Burbank, attorney for the California Inspection Rating Bureau, testifying for and on behalf of the insurance companies in California who carry workmen's compensation insurance, made the following statement:

I represent the California Inspection Rating Bureau, composed of the carriers of workmen's compensation in the State of California. We are marking time on the silicosis matter and are very, very active on certain other aspects. We are marking time from the standpoint of suggesting legislation. We will have no suggestions to make to you—have none now and will make none at the coming legislature. We are, on the other hand, exceedingly active from the standpoint of silicosis in our Safety and Engineering and Prevention Departments. Our aims are exactly those of the Industrial Accident Commission—the insurance carriers' aims are those of the Industrial Accident Commission, and I can say all right-minded employers have exactly in mind what Mr. MacDonald stated so well was the primary purpose of workmen's compensation, which is to prevent disease and to permit workmen to be employed under healthful conditions. We have a large staff of inspectors and are constantly working to devise ways of avoiding this risk to employees. Under the scheme of rates set up, it is worth while to an employer to participate and coöperate, and I can also say that Mr. MacDonald is 100 per cent correct in so far as our experience goes in saying that the employers have coöperated. I think you, Mr. Chairman, very aptly said a moment ago that the legislation suggested last season and perhaps the controversy over rates, while it was distasteful, nevertheless served a useful purpose by the publicity and argument that went on, in waking up the employers of the State. I wish to say in addition simply this, that we applaud and approve Mr. MacDonald's premise. His opening statement was very splendid and very fair, and while the Workmen's Compensation Act gives the Industrial Accident Commission ample police power, yet it is absolutely unfair of the State to expect them to discharge those duties and to police industries, as industry

must be policed and inspected and educated and advised, as they so well do, unless they have adequate help to do it. This is fundamental, but the fact is they have not had it and the workmen of the State are suffering on account of it through no fault of the Commission, which is entirely competent to direct that aid if the Legislature will give Mr. MacDonald the program he has outlined here, and it will be the most remunerative expenditure of money, I think Mr. MacDonald will agree, that the State could possibly make. I applaud and approve his program, and I am sure that we meet on a common ground; that all employers and their insurance carriers and everyone who does the right thing in this regard will agree, and I only hope that some concerted action to bring this to the attention of the Legislature will be taken.

Heart Disease Symposium at Los Angeles.—The fifth annual symposium on heart disease by the Los Angeles Heart Association, a Chapter of the California Heart Association, will be held in the Los Angeles County Medical Association Building, 1925 Wilshire Boulevard, January 28-29, 1937. This will be the fifth annual symposium of the Los Angeles Heart Association, and it is the desire of the Association to continue these annual meetings if the attendance is satisfactory. The present officers of the Association are: Dr. Arthur M. Hoffman, president; Dr. William H. Leake; Dr. George H. Houck, secretary.

The evening session on Thursday, January 28, will be a joint meeting with the Los Angeles Clinical and Pathological Society. The evening session on Friday, January 29, will be a joint meeting with the Los Angeles County Medical Association. The guest speaker this year is Dr. William Dock, professor of pathology at Stanford University Medical School, San Francisco.

This program has been arranged principally for the benefit of members of the medical profession in general practice in Southern California. All physicians who are interested in the various aspects of heart disease are urged to join the California Heart Association. The annual dues are two dollars.

The program includes the following:

THURSDAY, JANUARY 28

Evening Meeting, Eight O'Clock

(Joint Meeting with Los Angeles Clinical and Pathological Society)

Problems in Heart Disease

Clinical; Physiological; and Pathological

A Round-Table Discussion: Led by Howard F. West, M.D., Burrell O. Raulston, M.D., Verne R. Mason, M.D., John W. Budd, M.D., and William H. Leake, M.D.

FRIDAY, JANUARY 29

Morning Session, 9:45 O'Clock

Treatment of Cardiovascular Syphilis—George H. Houck, M.D.

Cardiac Abnormalities in Diseases of the Thyroid Gland—Walter A. Bliss, M.D.

The Sedimentation Rate in Coronary Thrombosis—R. Manning Clarke, M.D.

Peripheral Embolism in Heart Disease—William H. Leake, M.D.

Chest Pain in Heart Disease—Morris H. Nathanson, M.D.
Diagnosis of Cardiac Infarction—James F. Churchill, M.D. (by invitation).

Afternoon Session, Two O'clock

Diagnosis of Rheumatic Fever—E. Richmond Ware, M.D.
Diagnosis of Cardiovascular Emergencies—Donald J. Frick, M.D.

Treatment of Cardiovascular Emergencies—Lewis T. Bullock, M.D.

Diuretics—Hilmar O. Kocfod, M.D. (by invitation).

The Value of Auscultatory Findings in Heart Disease—William Dock, M.D. (by invitation).

Evening Session, Eight O'Clock

(Joint Meeting with Los Angeles County Medical Association)

Heart Disease as a Community Problem—Arthur M. Hoffman, M.D.

The Significance of Dyspnea—William Dock, M.D. (by invitation).

♦ ♦ ♦

Exhibits of pathological specimens and of electrocardiograms will be found on the second floor during the Friday sessions.

NEWTON EVANS, M.D.

R. MANNING CLARKE, M.D.

Medical Conference Clinics in Oakland.—A medical conference for general practitioners, initiated by the Alameda County Institutions Commission, approved by the Alameda County Medical Association and arranged by the staffs of the Alameda County hospitals in cooperation with the University of California Extension Division, will be held in Oakland during the week of February 1 to 5, inclusive.

The object of this postgraduate course is to give the general practitioner an intensive week of study and demonstration, covering the various problems that he meets daily in general practice. To accomplish this the various departments of the Alameda County hospitals have combined their resources to give a complete course, extending over a wide field. The program includes lectures by the medical staff, supplemented by surgical demonstration of the same topics by the surgical department. The course is open to general practitioners, graduates of regular schools of medicine.

The program will be given by the assistance of the staff of the Alameda County hospitals, with Dr. Benjamin W. Black, director, in charge, cooperating with the Extension Division of the University of California.

About forty physicians will participate in the program of study. Among those who have definitely been scheduled for a part in the program are: Doctors Benjamin W. Black (director), Charles A. Dukes, Sumner Everingham, Edward N. Ewer, Harold Hitchcock, Robert T. Legge, Albert M. Meads, William H. Strietman, Fletcher Taylor, and H. J. Templeton.

Instruction will begin at 8 a. m. and continue through the whole day until 9:30 p. m. daily from February 1 to 5. The Thursday evening meeting will be held with the Alameda County Medical Society. On Friday evening, conference members will be the guests of the hospital staff at a banquet at the Claremont Country Club.

The fee for the conference will be \$25.

Program of Courses

The complete program of the conference follows:

Medical Department.—Peptic ulcer—various symptoms, diagnosis, and modern treatment; thyroid and parathyroid—symptoms and laboratory findings; gall-bladder diseases—the clinical tests, the x-ray examinations and interpretations; cardiovascular diseases; tuberculosis—sanatorium care and clinic treatment followed by a display of chest surgery, illustrating the recently advanced surgical procedures; arthritis; glandular disorders—illustrated by a series of individuals presenting glandular dysfunctions; nutrition; leukemias and anemias—both clinic and laboratory study; pneumonia—with suggestions for home treatment; communicable diseases—presented at the isolation department, where a great variety of contagious diseases will be found; orthopedics—a discussion and presentation of the common fractures met in practice.

Surgical Department.—The surgical department will assist in the medical program by demonstrating the various operations resulting from these diseases, such as thyroidectomy, gastric surgery, gall-bladder surgery. The surgical department will also present the treatment of extensive burns and surgical shock, industrial surgery, and the surgery of hernias.

The neurology department will give special emphasis upon the diagnosis and treatment of fractured skulls, so commonly met with today in private practice, due to highway accidents. A demonstration of the procedure and value of spinal punctures, cisternal punctures, and encephalography will be presented.

The genito-urinary department will present the subject of hematuria in trauma and disease. Also the treatment of acute venereal disease will be given.

The dermatology department will present an illustrated demonstration of skin diseases that are of interest to the general practitioner together with the modern treatment of syphilis.

The gynecology and obstetrical departments will thoroughly cover the subject of pelvic examination with differential diagnosis of pelvic conditions. The obstetrical department will cover the subject of complications of pregnancy and will also report methods of handling maternity cases, following delivery. Arrangements may be

made for attendance at the delivery of cases all during the week.

The cancer clinic will present the subject of cancer, its early diagnosis, pathology, and treatment, from the great number of illustrative cases and will be followed by a demonstration of cancer surgery.

The pathologic department will hold an interesting clinical pathology conference.

The x-ray department will demonstrate the use of radium, radiation, and x-ray.

LETTERS

Concerning the fight against syphilis.*

CALIFORNIA MEDICAL ASSOCIATION
DEPARTMENT OF PUBLIC RELATIONS

December 5, 1936.

To the Editor:—You are quite aware that since Doctor Parran has assumed the office of Surgeon-General of the United States Public Health Service one of his outstanding objectives is to educate the public in regard to syphilis and its complications. One of the plans of the United States Public Health Service, under the Social Security program, is the conducting of a campaign that would be nation-wide for the eradication and treatment of those afflicted with syphilis.

The Department of Public Relations of the California Medical Association is commencing to receive inquiries from lay individuals as to where they may obtain dependable information and literature upon the subject. The Committee on Public Relations is preparing, after consultation with competent members of the profession, a bibliography that may be sent to these inquiring individuals. As far as the education of the public is concerned, this committee feels that the public will gain their educational information through the activities of the United States Public Health Service and the Social Security Administration. We, however, feel that a very serious problem arises with regard to the members of our profession and their competency to recognize as well as treat this affliction. We feel that there has been a lack of professional training and education due to more or less apathy on the part of educators and the prudery of the public press as well as society. Now when the attempt is being made to educate the public, if physicians are not brought up to a level of competency and do not provide adequate care for those who consult them they will be laying themselves liable to suits for malpractice.

To that end the committee feels that organized medicine must make a very effective effort to enlighten and instruct the members of the profession.

In the November, 1936, issue of the *Archives of Internal Medicine* there is a very splendid review of recent literature and an excellent discussion of the entire question of syphilis, prepared by Doctors Padget and Moore of Baltimore.

Several of the members of this committee feel that it would be most helpful if CALIFORNIA AND WESTERN MEDICINE were, in two or three issues, to reproduce this summary for the benefit of our members. We also feel that in each issue in the department of Bedside Medicine there should be a sustained or consecutive series of articles written by competent men for the education of our public.

I am sending these suggestions to you as chairman of the Committee on Public Relations, and respectfully request that you initiate these suggestions in CALIFORNIA AND WESTERN MEDICINE.

The committee is willing to be of all assistance possible. If we can be helpful to you, please call on us.

Sincerely yours,

C. A. DUKES, M. D.

Concerning reporting of syphilis and gonorrhea.

TREASURY DEPARTMENT
PUBLIC HEALTH SERVICE
WASHINGTON

November 16, 1936.

To Coöperating Health Officers:

During the last few years, health officers and others interested in the control of syphilis and gonorrhea have heard much regarding the development of an efficient system of reporting these diseases. The Public Health Service has been requested to institute studies aimed at the improvement of morbidity reports for syphilis and gonorrhea. Meanwhile, it is highly desirable to continue the old system of collecting morbidity reports, which has been in use in health departments for a decade or more.

Attention is invited to the large number of health departments which fail to submit morbidity reports to the Public Health Service at the present time. When the plan of publishing morbidity reports for syphilis and gonorrhea in cities with a population of 200,000 or more was instituted about ten months ago, practically all of the cities submitted reports. Considerable correspondence has been held with health departments since that time in which attempts have been made to encourage reporting. In spite of this, the present monthly statement indicates a grave lack of interest. From a study of the statements which are presented herewith, one gains the impression that the extent to which such reports are made varies in direct proportion to the interest and initiative of the health officers in the various states and cities.

By direction of the Surgeon-General.

Respectfully,

R. A. VONDERLEHR,
Assistant Surgeon-General, Division of
Venereal Diseases.

TREASURY DEPARTMENT
PUBLIC HEALTH SERVICE

State health officers' monthly statement of venereal diseases reported. For the month of September, 1936.

This statement is issued monthly for the information of health officers in order to furnish current data as to the prevalence of the venereal diseases. The following reports were received from state health officers. The figures are preliminary and subject to correction. It is hoped that this will stimulate more complete reporting of these diseases.

	Syphilis		Gonorrhea	
	Cases Reported During Month	Monthly Case Rates Per 10,000 Population	Cases Reported During Month	Monthly Case Rates Per 10,000 Population
California	1,358	2.41	1,484	2.63
Total (all states).....	22,087	1.86	15,101	1.27

Monthly statement of venereal diseases reported in California cities with populations of 200,000 or over. For the month of September, 1936.

	Syphilis		Gonorrhea	
	Cases Reported During Month	Monthly Case Rates Per 10,000 Population	Cases Reported During Month	Monthly Case Rates Per 10,000 Population
Los Angeles	361	2.52	368	2.57
Oakland	36	1.19	55	1.81
San Francisco *.....	....	....	....	....

* No report for current month.

Concerning acknowledgment of Widney reprint.

LIBRARY OF CONGRESS
DIVISION OF ACCESSIONS
WASHINGTON

To the Editor:—By direction of the librarian, I beg to acknowledge with cordial appreciation the receipt from you of the gift mentioned below, a welcome addition to the collections of the Library of Congress.

Very truly yours,

FAUSTON DOWNIS,
Acting Chief, Division of Accessions.

A copy of: "Joseph Pomeroy Widney, . . . Founder of the Los Angeles County Medical Association and of the College of Medicine of the University of Southern California, civic worker and author; some biographical notes on a colleague, who, at the age of 95, still 'carries on.' By E. T. W."

* See editorial comment in this issue, page 3.

Concerning need of adequate inspection of foods canned in foreign countries.

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

To the Editor:—At Doctor Geiger's direction, I am sending you the attached copy of an open letter to health officers. This letter has been sent to all state and territorial health officers and to the health officers of one hundred of the larger cities of the United States, and to a number of executives within the canning industry.

Doctor Geiger thought you might be interested in seeing a copy of the communication, inasmuch as it represents an attempt to secure new legislation which will permit of adequate supervision and regulation over canned products of both domestic and foreign origin.

On authority from the Director of Public Health.

Sincerely,

JACQUES P. GRAY, M. D.,
Assistant Director of Public Health.

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CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

December 8, 1936.

An Open Letter to Health Officers:

From time to time, outbreaks of botulism have been traced to foreign canned products. Botulism has occurred in California in the past year in two outbreaks, involving fourteen people and causing, among these, six deaths. In one instance, the source of infection, epidemiologically, was traced to antipasto, a vegetable-fish product packed in one of the southern European countries; in the other outbreak, clams packed in an oriental country were responsible.

As a result of these two incidents, I addressed a communication to representatives of the United States Department of Agriculture, Food and Drug Administration, pointing out the desirability of adequate supervision over foreign canned products coming into this country and the justification for establishing safeguards similar to those required in this country in the packing of such products, so that the American consumer desiring canned products of foreign origin might be assured of the safety of such products since they would be packed under conditions involving techniques comparable to those followed in American canneries. In his reply, the Chief of the Division of State Cooperation, W. S. Frisbie, stated that existing legislation does not grant authority for the establishment of standards for canned products coming in from foreign countries. He also pointed out that the "present action and control of imported goods is quite as rigid and along the same lines as that exercised over domestic products"; also, that as a matter of fact "there are no provisions, under the Federal Food and Drug Act, which confer any authority upon the Food and Drug Administration to insist upon certain standards of processing for canned goods in foreign countries or in domestic commerce." In other words, it appears that the present high standards of canned products packed in the United States of America have been developed as the result of more or less self-imposed rigid requirements and standards as promulgated by the canning industry itself with the assistance of its consultants.

Under these circumstances it would seem that there is a definite need for widespread development of public opinion favorable to suitable legislation, giving broad powers and genuine authority to the United States Department of Agriculture or other suitable federal agency, permitting adequate supervision of commercially prepared canned food products whether packed in foreign or domestic canneries. The American consumer certainly deserves a safe canned product at all times and from all sources.

May I have your comment on this subject? Your assistance in developing public opinion favorable to worthwhile action in Congress, I am sure, would be helpful to your congressmen and senators.

Sincerely,

J. C. GEIGER, M. D.,
Director of Public Health.

Concerning contribution of California Medical Association to Lane Library.

December 22, 1936.

Dr. F. C. Warnshuis,
Secretary, California Medical Association,
450 Sutter Street,
San Francisco.

My dear Doctor Warnshuis:

It is so fine to be able to end the year's bookkeeping for the library by adding the check for \$122.50 that you have just sent to us. We certainly appreciate the help that we have received from the California Medical Association.

All of the Library staff send many thanks and holiday greetings.

Very truly yours,

LOUISE OPHÜLS,
Medical Librarian.

Concerning prizes for essays on thyroid gland.

AMERICAN ASSOCIATION
FOR THE
STUDY OF GOITER

November 20, 1936.

To the Editor:—The American Association for the Study of Goiter again offers the Van Meter Prize Award of \$300 and two honorable mentions for the best essays submitted concerning experimental and clinical investigations relative to the thyroid gland. This award will be made at the discretion of the Society at its next annual meeting, to be held in Detroit, Michigan, June 14, 15, and 16.

The competing manuscripts, which should not exceed 3,000 words in length, must be presented in English and a typewritten double-spaced copy sent to the corresponding secretary, Dr. W. Blair Mosser, 133 Biddle Street, Kane, Pennsylvania, not later than April 1, 1937. Manuscripts received after this date will be held for competition the following year or returned at the author's request.

The committee who will review the manuscripts is composed of men well known in the fields of research and clinical investigation of problems related to the thyroid gland. At the last annual meeting of the Society the award for the year 1936 was presented to Dr. Edward Uhlenhuth, University of Maryland Medical School, Baltimore, Maryland, in appreciation of his manuscript entitled "Isolation of the Thyreosactivator Hormone from the Anterior Lobe of the Bovine Pituitary Gland." The committee also awarded honorable mention to Dr. E. Cowles Andrus and Dr. Donald McEachern, Johns Hopkins University and Hospital, Baltimore, Maryland, for their manuscript entitled "On the Nature of the Increased Metabolism in Hyperthyroidism."

The Association will publish the manuscript receiving the prize award in their annual proceedings, and reserve a place on the program of the annual meeting for presentation of the manuscript by the author, if it is possible for him to attend. This will not prevent its publication, however, in any journal selected by the author.

Very truly yours,

W. BLAIR MOSSER, M. D.,
Corresponding Secretary.

Concerning editorial on hospitalization plans.

To the Editor:—In your editorial, Hospitalization Plans in California, in your December issue, you write:

Of course, certain matters having to do with clinical laboratory and x-ray services, which today are everywhere accepted and demanded as concomitants of hospitalization, may need satisfactory adjustment; but the difficulties in regard thereto should not be unsurmountable.

The meaning and intent of this sentence is quite clear to those familiar with the subject, but since it will be read by many who are not, it would seem that the following facts are worth bringing to the attention of your readers. This editorial appears in the official journal of the California Medical Association; the House of Delegates of that Association has rendered its belief in no uncertain

terms that laboratory and x-ray services are just as much medical services as pediatric and surgical services; therefore, it might be fairer to state that the problem of furnishing these services on an insurance basis *must* receive some adjustment. The lines referred to also suggest that clinical laboratory and x-ray services are peculiar in being "concomitants of hospitalization"; are not medical and surgical services also concomitants of hospitalization? Finally, if one must be humanitarian, one must observe that the big health bill facing hospitalized citizens of moderate income is neither the hospital bill nor the x-ray bill; it is the surgical bill or the medical bill, and quite properly so. The operating surgeon, the family physician, the internist, devote untold time and energy to the care of their patients and deserve the fees they charge. However, from the point of view of the subscriber it would be very pleasant to have these fees also included in his benefits; to him they are just as much concomitant services as the radiologist's and justifiably much more costly.

Hospitalization insurance that provides hospitalization is both meritorious and desirable. Health insurance that provides medical care seems to be desired; the two should be clearly separated not only because hospitalization is the subject of your editorial, but also because the layman who directs the one may not be the ideal director of the other. I am

Yours very truly,

L. H. GARLAND, M. D.

Concerning space given to American Red Cross.

THE AMERICAN RED CROSS
NATIONAL HEADQUARTERS
WASHINGTON, D. C.

December 1, 1936.

California and Western Medicine,
San Francisco, California.

Gentlemen:—Please allow me to express to you, in behalf of our national officers, our very sincere appreciation for the generous contribution of space which you gave to the American Red Cross in CALIFORNIA AND WESTERN MEDICINE. It is only through the splendid cooperation which you and others give us each November that we are enabled to extend a universal invitation to all Americans to participate in Red Cross work through individual memberships.

Cordially yours,

DOUGLAS GRIESEMER,
Director of Roll Call.

Concerning State Health Board cooperation in campaign against syphilis.

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH
SACRAMENTO

December 17, 1936.

F. C. Warnshuis, M. D.,
Secretary, California Medical Association.

Dear Doctor Warnshuis:

I desire to acknowledge your letter of December 16, designating the names of the committee appointed by the California Medical Association to cooperate with the State Department of Public Health in the campaign for the control of syphilis in this state.

We shall be most pleased to work with the committee, and solicit the interest of the members of the Association through said committee.

Very truly yours,

W. M. DICKIE, M. D.,
Director of Public Health.

Concerning new amputation, lower third of thigh.

To the Editor:—In the Journal of the American Medical Association for November 30, 1935, and in CALIFORNIA AND WESTERN MEDICINE, September, 1936, I described a new amputation in the lower third of the thigh.

This letter is an attempt to canvass the doctors within reach of these journals in order to evaluate through them the results obtained from this operation.

Information is desired on the following points:

Number of patients operated; mortality; condition for which the operation was performed; condition of the patient before the operation; complications.

I would appreciate discussion of any unusual difficulties which may have been encountered in the performance of this operation along the lines laid down in the above articles, also suggestions of changes in the technique which might be beneficial. Proper acknowledgment will be made for the use of case histories submitted.

C. LATIMER CALLANDER, M. D.

450 Sutter Street,
San Francisco, California.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.

San Francisco

Are Municipal Ordinances Imposing a License Tax Upon Physicians Valid?

A great number of cities and towns in California have ordinances under the terms of which all physicians engaging in practice within their respective boundaries are required to secure licenses—ostensibly for the privilege of engaging in the practice of medicine and surgery. In each of these ordinances the only requirement for a license is the payment of a prescribed fee. Within the past two years the legal department of the California Medical Association has received requests for opinions on the subject under discussion from members of the Association practicing in a number of different municipalities, including San Francisco, Modesto, Petaluma, and Isleton. In view of the number of inquiries received, it has occurred to us that a discussion in this column of licensing ordinances, in so far as they may apply to the medical profession, would be appropriate.

The power of a city or town to impose a license tax upon physicians for the privilege of engaging in the practice of medicine within the municipality is subject to certain limitations. In order to discuss these limitations it is necessary preliminarily to state that there are two types of license tax. The first type is a license tax imposed for the purpose of defraying the cost of inspection and regulation of the business or profession subjected to the tax. The second type is one solely for the purpose of raising revenue for the general expenses of the municipality.

The first type, that is, a license tax for the purpose of inspection and regulation, is within the power of all municipalities (Political Code, Sec. 3366) subject to a specific limitation, namely, that the license tax may only be levied upon those businesses and trades which are subject to the police power. Any business, trade or profession which may not be inspected or regulated by the municipality under its general police power may not be subjected to a license tax which has as its sole purpose the defraying of the cost of inspection and regulation. The medical profession as such is not subject to inspection and regulation by municipalities and, therefore, it falls within the limitation under discussion. In *City of Sonora vs. Curtan*, 137 Cal. 583, our Supreme Court held that the city of Sonora lacked power to impose a license tax upon attorneys-at-law for the purpose of defraying the cost of regulation and inspection. In *City of Redding vs. Dozier*, 56 Cal. App. 590, it was clearly indicated that the same rule applies with respect to the medical profession. Therefore, we may conclude that municipal licensing ordinances which have for their purpose the defraying of inspection and regulation costs are invalid in so far as they attempt to impose a fee or tax upon physicians practicing within the community.

With respect to the second type of license tax, that is, a license tax for the purpose of raising revenue, a some-

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, containing copy submitted by Hartley F. Peart, Esq., has been established by the California Medical Association Council. Each issue will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession. These will be compiled by Hartley F. Peart, General Counsel of the Association.

what different principle governs. A license tax for the purpose of raising revenue may not be imposed by any municipality upon any business, trade or profession unless the State Legislature has by statute expressly delegated to the particular municipality concerned the power to impose such a tax. There are a number of cities and towns in the State which have never received authority from the Legislature to impose license taxes for the purpose of raising revenue. On the other hand, by statute, all of the cities of the sixth class are authorized to raise revenue by means of imposing license taxes upon any business, trade or profession. Likewise, the Legislature has approved a number of city charters which contain specific authorizations to license for the purpose of raising revenue. It is impractical here to attempt to enumerate all of the California cities and towns which have received legislative authorization and those which have not.

If a particular municipality has been authorized by the Legislature to impose license taxes for revenue-raising purposes upon all business, trades and professions, then in that event a municipal ordinance imposing a license tax upon physicians is valid and enforceable.

In determining whether or not a particular municipal ordinance imposing a license tax upon physicians is or is not enforceable as against the physicians in the community, one must be able to answer two separate questions: (1) Is the ordinance imposing the tax a revenue-raising measure or is its sole purpose that of defraying the cost of inspection and regulation; and (2) If it is a revenue-raising measure, has the Legislature conferred specific authority upon the municipality to impose license taxes upon the professions for revenue purposes?

* * *

Expert Witnesses in Malpractice Cases May Not Be Required to Give a Yes or No Answer to an Hypothetical Question and Must Be Allowed to Explain Each Answer.

On November 7, 1936, the District Court of Appeal for the Second Appellate District decided the case of *McGuire vs. Dr. Marion W. Baird*, 87 C. A. D. 436. From the opinion of the court it appears that the case was a malpractice action against a physician and that during the course of the trial one of the attorneys propounded a somewhat lengthy hypothetical question to a physician, who had qualified as an expert witness. Upon the insistence of the attorney who had propounded the question the trial court ruled that the witness would have to answer it either "yes" or "no," and that the witness could not give a qualified answer or an explanation of the reasons for his answer. On appeal before the District Court of Appeal, it was held that the trial court committed prejudicial error in refusing to allow the expert witness to qualify his answer and give such explanations therefor as he saw fit.

Inasmuch as it is possible for an attorney so to phrase a lengthy hypothetical question that the witness cannot conscientiously and honestly answer the question either "yes" or "no," but must, in order to tell the truth, qualify his answer and state his reasons therefor, it is important to remember that under the law a physician who is on the witness stand as an expert witness cannot be forced to answer a hypothetical question "yes" or "no" when, in his opinion, an explanation is necessary.

SPECIAL ARTICLES

PARIS EXPOSITION WILL DEVOTE SECTION TO MEDICINE AND SCIENCE

A liberal education in the field of modern medicine and a comprehensive survey of resultant achievements will be one of the many interesting attractions at the Paris 1937 International Exposition.

According to present plans announced by the French High Commissioner, three huge pavilions will be devoted to this unusual display. Special emphasis will be placed on the precise scientific character of modern medicine as

compared with the hit-or-miss methods of the nineteenth century. The exhibit which naturally will be of great interest to all members of the medical profession and its allied fields, will be so arranged and displayed as to be easily understood by the layman.

The three great halls, each reverently dedicated to a great name in French medical history, will be devoted to the illustration of the various phases of medicine and its allied sciences. The Claude Bernard Pavilion, so named in honor of the great pioneer in physiology, will contain among many other unique exhibits, a transparent man, illuminated to show the glands, nervous system, and general anatomy. Another of the exhibition halls will be called Laennec Pavilion, to perpetuate that name, noted as a creator of clinical medicine and the inventor of auscultation, which is a method of diagnosis concerned with the sounds produced by the human body. In this building will be shown a remarkable and important collection of instruments, books and relics of nineteenth century medicine. Along with this will be a display of modern medical instruments and equipment, illustrating the advances of the past fifty years in the science of medicine. Such exhibits will be chronologically arranged to demonstrate the steps in medical progress from the dark ages of ignorance, through the enlightenment of experimentation and research, into the brilliancy of modern scientific methods and achievements.

Every branch of medicine will be represented and treatment for certain diseases will be demonstrated in many cases. Moving pictures will be employed to show scientific experiments, research into causes of infection and illness, and methods of treatment. Everything possible will be done to clarify in the mind of the layman the scientific and technical accomplishments of modern medicine.

In addition to presenting a comprehensive view into medical history and present-day practice, this exhibition will offer a remarkable insight into the probabilities of the medical science of the future. The strides which scientific research is making in the conquest of illness will be demonstrated. Government regulation of sanitation will be stressed in the light of its importance in the fight for world-wide health and happiness and the necessary contribution of industry to the elimination of disease will be emphasized.

Illustrations will clarify the gradual elimination of the age-old barriers between medicine and the allied sciences which have stood in the path of progress since the days of medicine's first crude efforts. The debt to chemistry and physics will be explained, without whose coöperation we would still lack such important curative and diagnostic agents as radium and the x-ray. The endless collaboration of energies working for the benefit of mankind will be described, and civilization's hopes in the never-ending struggle against disease and death will be indicated at the Paris Exposition next May.

NATIONAL SOCIAL HYGIENE DAYS

Plans for the first National Social Hygiene Day, to be held February 3, 1937, are announced by the American Social Hygiene Association of 50 West Fiftieth Street, New York City. On this day, state and community voluntary organizations interested in the control of syphilis and gonorrhea and other social hygiene problems, with the advice and approval of health authorities and the medical and allied professions, are planning to hold meetings all over the United States.

In New York City the American Social Hygiene Association will hold its annual meeting on February 3. Also the Social Hygiene Council of Greater New York will hold its fifth annual regional conference at the Hotel Pennsylvania on the same day. It is expected that public leaders, including Surgeon-General Parran, President Ray Lyman Wilbur of Stanford University, President of the American Social Hygiene Association and former Secretary of the Interior, will speak to these meetings. National agencies and many of their state and community organizations which include social hygiene activities in their yearly programs are planning to participate. It is probable that a nation-wide radio hook-up will provide

addresses of great importance from high government officials and civic leaders in different parts of the country as a climax to the activities of the First National Social Hygiene Day.

There has been definite progress all along the line during the past year in public understanding and support of the campaign against syphilis. Newspapers and magazines are opening their columns to public discussion of this health menace to a greater extent than ever before. Certain important groups, such as the General Federation of Women's Clubs and the National Council of Women, are adopting the fight against syphilis as among their next major efforts in promoting community health. (The women's groups are particularly interested in the elimination of prenatal or congenital syphilis, which, acquired by a child before birth from an infected mother, is responsible for a large share of stillbirths, miscarriages, and defective children, and which is entirely preventable by proper treatment.)

Service luncheon clubs, such as Rotary, Kiwanis, and Lions, have recently been undertaking social hygiene programs. Business leaders are studying the cost to industry from lost time, lowered efficiency and hospitalization, due to syphilis. The large insurance companies are concerned over the unnecessary claims for death and disability due to syphilis. Civic clubs, forums, and town meetings are discussing the diagnosis and treatment of syphilis as a national plague.

It is believed that the direction of united nation-wide attention to this subject in the way that is proposed will help professional and lay community leaders to capitalize and increase this new interest, and consolidate for further advance toward meeting General Parran's challenge to "stamp out syphilis."

MUTATION AND THE ORIGIN OF CANCER

Some years ago Boveri advanced the theory that cancer cells were those in which the tiny microscopic bodies called chromosomes were abnormally distributed. In every normal body cell there is contained a definite fixed number of chromosomes which is characteristic of the species. Thus, in every normal body cell of a man there are forty-eight, and in every normal body cell of a mouse forty of these structures.

Boveri noticed that in certain cancers there was an abnormal distribution of chromosomes, during cell division in many of the cells. As a result of this, there were cells formed in which a great excess of chromosomes occurred. There were also cells formed which were deficient in chromatin material. Boveri looked upon the abnormal distribution as the cause of cancer.

As time passed, evidence against his hypothesis was derived from two sources. The first, of an indirect but interesting nature, came from genetics or the study of heredity. Blakeslee, Belling, and others, working with the jimson weed, *Datura*, showed that markedly abnormal distribution of chromosomes could be obtained without resulting in anything resembling tumorous or cancerous growth. They further showed that cells or plants in which the distribution of chromatin was asymmetrical or unbalanced were distinctly less vigorous and died at a much earlier age than did normal ones. Since cancer is characterized by an immense vitality and growth energy, this evidence did not look at all promising for Boveri's theory.

It was not, however, until workers with tissue culture were able to observe the living and dividing cells of rat and mouse cancer that direct evidence on Boveri's hypothesis could be obtained. In a number of different tumors it was found that cells with asymmetrical distribution of chromatin divided much more slowly than the cells in the same tumor which had the normal number of chromosomes. As a result the abnormal cells were certain to leave fewer descendants than were the normal cells. The tumor would, therefore, constantly tend to show a steadily increasing proportion of normal cells and the cause and effect relationship of abnormal chromosome distribution and cancer formation is entirely broken down.

In spite of this fact Boveri did science a great service by providing those who felt that the significant difference between a cancer cell and its normal forbears was some sort of change within the cell itself, a theory that could be actually tested. In the development of the interest which his hypothesis aroused, research workers naturally focused their attention on other biological processes which might possibly serve to explain the nature of the change from a normal to a cancerous cell.

Among the most promising of the tentative hypotheses advanced was that of Tytzer, who in 1915 pointed out that the change under consideration fulfilled the conditions encountered when a process known as mutation occurred. He recognized frankly that the theory which he suggested was extremely difficult of experimental test, but offered it for what it was worth and to stimulate discussion. This it certainly did, for at intervals during the past twenty years other investigators have independently advanced the same theory.

The term "mutation" means sudden change. It was first given an important rôle in the process of evolution by a Dutch botanist, de Vries, in 1900. De Vries believed that evolution proceeded most commonly by a series of sudden discontinuous variations which were perpetuated by inheritance and were, therefore, essentially permanent.

For some years there was not sufficient knowledge of the process of heredity available to determine what the relationship between the appearance of a mutation and the presence of chromosomal changes might be. Then, by the work of Morgan and his associates and by utilizing the hypothesis of hereditary units suggested by Cuenot, the whole problem began to assume a more integrated and consistent form.

The simplest hereditary units called "determinants" by Cuenot were given a shorter designation, "genes," by Johannsen. They were found by Morgan and his co-workers to be closely associated with the chromosomes and to act as though they were arranged in a linear series in or on the individual chromosomes. Their relationship to one another was shown to be fixed, measurable, and predictable.

Mutation of the sudden and permanent change of these genes became a problem capable of some degree of experimental control and investigation. It was found that certain physical and chemical factors increased the rate at which the sudden changes or mutations occurred. These factors could be varied experimentally. The whole question took on a new and more general importance.

It soon became evident that sudden and permanent changes in the smallest hereditary units or genes were not the only type of mutations which occurred and which could be induced. The work of Blakeslee and Belling, to which reference has already been made, gave clear evidence that whole chromosomes could be doubled or even quadrupled and that, therefore, new numerical chromosome combinations could be made. When this occurred suddenly and was handed down by heredity and conditions of a mutation were fulfilled and the definition of that process had to be extended.

Gradually it became clearer that, between the chromatin material of the cell and its surrounding cytoplasm or cell substance, complicated relationship existed which might be suddenly and permanently disturbed and altered. We do not yet know the relative importance of chromatin and cytoplasm in the origin and perpetuation of these changes. It seems, however, more than possible that in the sudden appearance of one or more changes of this mutational sort may be found the origin of the biological variation in the type of cellular behavior known as cancer.

Such a change or changes might result from any one of a number of influences. The so-called carcinogenic agents, which are almost monthly increasing in number, may be one category of stimulative factors. A group of internal secretions as yet incompletely analyzed, occurring naturally in the body, may provide another source of potential interest as possible mutation-increasing substances. There may be and probably are many others as yet undiscovered roads to increased mutation rate. Cancer research of the future has these problems before it. In the meantime the conception that the cancer change itself

may be a mutation excludes no existing evidence and provides a consistent and attractive working hypothesis by which important advances should be made.—*Bulletin of the American Society for the Control of Cancer.*

CANCER DEATH RATE FOR 1935 HIGHEST ON RECORD*

In a recent analysis of deaths from cancer, Frederick L. Hoffman, LL. D., Biochemical Research Foundation of the Franklin Institute, Philadelphia, points out that the cancer death rate for 184 cities with a population in 1935 of nearly 46,000,000 was 125.6 per hundred thousand of population against a rate of 123.1 in 1934, establishing the highest death rate from this cause since records have been carefully observed. The actual number of deaths in the 184 cities increased from 55,201 in 1934 to 57,309 in 1935, while 107 cities reported increases and seventy-seven decreases in their cancer death rates. The ten cities with the highest cancer death rates were Madison, Wisconsin, 286.8; Concord, New Hampshire, 238.4; Portland, Maine, 229.4; Pasadena, California, 218; Troy, New York, 187.6; Boston, 187.3; Shreveport, Louisiana, 185.2; Pittsfield, Massachusetts, 183.5; Spokane, Washington, 182.8, and Quincy, Illinois, 178. In the five largest American cities, Chicago, Detroit, Los Angeles, New York, and Philadelphia, the highest rate (147.5) was returned for Philadelphia. Detroit was the only city in this group to show a decrease (67.8). Presenting comparative rates in certain foreign countries, Doctor Hoffman points out that Switzerland reported an increase from 115.8 per hundred thousand of population in 1907 to 147.3 in 1934. Death rates, based on specified types, were 43.2 per thousand for cancer of the female genital organs in single women (25 years old and over), compared with 64.6 for married, widowed and divorced women. For cancer of the breast the rate for single women was 54.6, and for married, widowed and divorced women it was 49.1.—*Bulletin of the American Society for the Control of Cancer.*

BLINDNESS AND ITS CAUSES**†

It was with some misgiving that I accepted the assignment of reporting to you some facts about blindness. Available source data are scarce and in many respects unreliable, and unfortunately I do not belong to the group of statisticians who enjoy making estimates that resemble rabbits drawn out of the magician's hat. However, if you are willing to accept the statements for what they are—mere indications of the probable truth—and will focus your attention as much upon what it might be desirable to know as upon what we already know, perhaps I can give you a general background of information.

But why analyze blindness? There are two reasons why analysis is important. In the first place, for the sake of the individual who is blind or potentially blind, it is important that everything possible should be known about his condition. That this is so can be shown by the following case, which is illustrative of many that are to be found in the records of commissions for the blind and schools for the blind. . . .

Our second reason for desiring thorough analysis of cases is that the facts concerning them may be summed up to produce for administrators, who are planning prevention of blindness and work for the blind, the necessary basis for sound planning. For example, the acceptance of routine Wassermanns of pupils in schools for the blind is partly attributable to group statistics showing syphilis to be an important cause of blindness among children.

How shall we analyze blindness? What are the essential facts?

* J. A. M. A., October 3, 1936.

**Address by Miss C. Edith Kerby, Statistician of the National Society for the Prevention of Blindness, at the annual conference of the Society in Columbus, Ohio, afternoon session, Friday, December 4, 1936.

† Under the program of the Social Security Act, commonwealths wishing to receive federal aid in the care of the blind will be expected to keep accurate records. The California Department of Public Welfare is making a study of possible revisions of its examination form blanks.

Perhaps the most frequent question which has come to me concerns the number of blind in the United States or in some particular section of the country. On this point, the enumeration made in 1930 by the Bureau of Census gives the figure 65,431. However, this is admitted by the Bureau of Census to be an understatement. Consequently, in the same year also, the American Foundation for the Blind attempted to estimate the true figure by comparing census figures with registers kept by commissions for the blind in certain states, and arrived at the figure 114,000. Even this figure is open to question, chiefly because the various states differ in their concept of who is to be considered blind.

This brings us to our next point of analysis. If we are to secure data that is worthy of the name "statistics of the blind," we must consider how we shall define the term "blindness." One possible approach to this problem is that all states shall be brought into agreement on the definition of blindness. At the present time, among the thirty-three states having blind relief laws, there are ten which define blindness in terms of degree of vision, but there are seven different degrees, varying all the way from "loss of both eyes" to "visual acuity of 20/200." Fifteen additional states use indefinite statements such as "vision insufficient for tasks for which eyesight is essential." The remaining states have no definition mentioned in their laws. In spite of this variation, there is apparent at the present time a tendency to set the dividing line between the blind and the seeing world at visual acuity of 20/200, and to include in the blind group also individuals who have a peripheral field defect which limits the field of vision to an angular distance no greater than 20 degrees.

Even with a reasonably uniform definition of blindness, it is important to have some knowledge of the varying degree of visual handicap included among "the blind." The man on the street, with no knowledge of the problems involved, will define a blind person as "one who cannot see," by which he usually means an individual who is totally blind or who has light perception only. As a matter of fact, this description would cover about one-half to two-thirds of the persons usually considered blind. Among the recommendations of the Committee on Statistics of the Blind is a classification by degree of blindness which calls for five groupings. In Group 1 are those who are totally blind or who have mere "light perception." In Group 2 are those having "perception of motion" or only a negligible amount of "form perception" (under 5/200). Group 3 covers those having "traveling sight" (visual acuity of 5/200, but not 10/200). Group 4 includes those able to read large headlines (visual acuity of 10/200, but not 20/200). Group 5, or "the border-line" group, includes those having visual acuity of 20/200, and also those whose central visual acuity may be better than 20/200, but who have another visual defect—usually limitation of fields.

In analyzing a case of blindness, vision tests should be sufficiently accurate to enable us to classify the case in accordance with a scheme such as the one outlined. This knowledge of the degree of handicap is of interest not only to the statistician, but also to the administrator or case worker who may wish to use it as a guide in solving training or placement problems. It goes without saying that the ophthalmologist is obviously the best person to make an adequate determination of degree of vision.

The chief reason for selection of an ophthalmologist to give the eye examination, however, is to insure an adequate diagnosis. To be adequate, a diagnosis should indicate not only the part of the eye affected and the nature of its disorder (topographical factor derived from the Greek words meaning "to record the place"), but also the underlying cause of the eye condition (etiologic factor from the Greek "study of causation").

Wherever we have been forced to rely upon the records of old examinations, or upon recent examinations of cases which have occurred years ago, we have found practically no information as to etiology available. As a matter of fact, only the more recent studies of causes of blindness tend to give any etiologic data, although, oddly enough, the older studies did make reference to certain etiologies, such as accidents. With the gradual adoption of the cause of blindness classification of the Committee on Statistics of

the Blind, we are beginning to acquire statistical data on causes of blindness in which the cases are cross-classified both by topographical and etiologic factors. Much more time and emphasis need to be placed upon gathering such cause data.

The major responsibility for examination necessarily rests with the ophthalmologist, but nurses and case workers in general can make a noteworthy contribution, first by educating the public to the importance of eye examination; second, by referring suspected cases for examination at the time of occurrence of blindness, or preferably before; and third, by gathering for the examining physician authentic facts about the histories of the cases.

Although, as I have indicated, existing information is far from complete and satisfactory, it may be of interest to note the following facts indicated by available data. Causes of blindness will be classified under the two headings mentioned above.

Cause of Blindness—Etiologic Factor

1. The most numerous group in any table at the present time is invariably the "unknown." Fully 40 to 60 per cent of all cases fall into this group. . . .

2. Of the known causes, the most important group is that of the infectious diseases which account for from 15 to 25 per cent of the cases.

Syphilis and ophthalmia neonatorum (babies' sore eyes) are the most important diseases in this group. Although figures are particularly incomplete for syphilis, this disease is probably responsible now for more new cases of blindness among children than is ophthalmia neonatorum, and the figure for cases occurring among adults may be much larger than that for children. If the recently organized antisiphilic campaign proves effective, we may see within the next generation the same spectacular reduction in blindness from syphilis which has occurred during the past thirty years in the case of ophthalmia neonatorum (incidence has been reduced 75 per cent since 1907).

Other significant causes included in the group of infectious diseases are trachoma, meningitis, septicemia, tuberculosis, scarlet fever, measles, smallpox, and diphtheria. No one of these causes looms very large, with the possible exception of trachoma which, as you know, is very prevalent in some sections of the country and practically nonexistent elsewhere.

3. Accidents form the next largest group, being responsible for 15 per cent or more of blindness. Unfortunately a large proportion of the cases are indefinitely specified merely as trauma. Hence it is impossible to give any satisfactory analysis of the causes of eye accidents.

4. The congenital and hereditary cases are probably responsible for about 10 per cent of blindness in the general population. Among the child population this is, however, the most numerous group. In the current studies of causes of blindness among children made by the Committee on Statistics of the Blind, 50 per cent of the cases are attributed to these causes, although it is felt that at least a portion of the cases should more properly be classified under congenital syphilis. Moreover, our congenital cases need further study to determine whether the condition is hereditary or could be prevented by proper prenatal care.

5. The remainder of the cases are divided among the noninfectious systematic diseases, such as vascular diseases, nephritis, diabetes, etc., and the neoplasms and toxic poisonings. In our present statistics, less than 5 per cent of the cases are attributed to noninfectious systemic diseases. Undoubtedly, this group will prove much larger when causal relationships have been more definitely established by the medical profession.

Causes of Blindness—Topographical Factor

1. About one out of four cases of blindness in the general population appears to be due to cataract. The cases are mostly of the senile type, but congenital and traumatic cataracts are also included. In view of the fact that surgical treatment of cataract is possible, and generally successful in uncomplicated cases, the existence of this large group of individuals with cataract presents a challenge to

case workers, such as public health nurses. Undoubtedly, there are many whose condition might prove to be amenable to corrective treatment.

2. Optic atrophy ranks second on the list. It includes about 15 to 20 per cent of the cases. The etiologic factor is not mentioned in most cases. However, indications are that the most important single cause of this condition is syphilis, with trauma, meningitis, neoplasms, and non-infectious diseases responsible for the remainder.

3. Glaucoma causes more than 10 per cent of blindness. Its etiology has not as yet been established and, as you know, the only hope for preventing blindness from this disease lies in medical supervision which is instituted early and carried out continuously throughout life.

4. Disorders of the choroid and retina account for about 10 per cent of blindness. Perhaps degeneration of the retina, which is usually considered hereditary in origin, is the largest single cause in this group. The group also includes detachment of retina as well as various inflammatory and atrophic conditions of these membranes. The latter are frequently designated as associated with infection, although the nature of the infection is not specified.

5. Affections resulting in opacities of the cornea (largely ophthalmia neonatorum, syphilis, and, in some places, trachoma) are responsible for about 10 per cent of blindness.

6. Developmental anomalies and degenerative changes in the eyeball account for another 10 per cent. The former are congenital in origin, and most of the latter are associated with trauma.

7. Uveitis and affections of the iris and ciliary body rank next with more than 5 per cent, these cases being attributed to infections and trauma.

8. Refractive errors, chiefly myopia, account for only a small percentage of blindness (under 5 per cent in this country, but it is interesting to note that European figures show a much higher incidence).

Age at onset of blindness should also be determined as definitely as possible at the time of the eye examination. Frequently, the ophthalmologist will welcome investigation by the nurse or case worker on this point. It may not be an easy matter to determine the exact age at which the individual loses his sight. Nevertheless, it is helpful to try to do so, since the ophthalmologist may be guided by this information in making his prognosis, the worker for the blind will use it in determining the need for special training, and, finally, to the statistician, it supplies a fact which is valuable in itself as well as useful in determining trends. Although information on this point is quite as incomplete and inaccurate as that on causes of blindness, it may be of interest to quote the figures given in the 1920 census. If we weigh the ratios given in that report according to the Foundation's estimate of the true total, we find that the incidence of blindness among children under five years of age is about two in ten thousand. The rate falls off during the preschool, school, and the adolescent ages, but again reaches two at about the age of thirty-five. It increases up to the age of sixty, when it is about nine in ten thousand, and very rapidly thereafter until it reaches a very high rate of seventy-five in ten thousand at the age of eighty or over. At first glance, these figures seem to confirm the popular theory that if one lives long enough, he may become blind. (The chances are 1 in 130 for persons over eighty years.)

The ophthalmologist's examination will ordinarily include his prognosis and more or less definite recommendations for care and treatment to restore or preserve vision, when this is possible.

If all of these essential facts concerning the individual's eye condition are noted on his eye examination record, the particular type of record form that is used is immaterial. However, it may be desirable to call attention to the suitability of the eye examination form prepared by the Committee on Statistics of the Blind for this purpose. (This form is at present undergoing a slight revision which was decided upon at the time that the Social Security Board was developing its recommended form which is modeled closely on that of the committee.) Its items call for factual information summarized in a form which lends itself readily to tabulation.

One further word of warning concerning the statistics which I have given. They are based on a comparative analysis of such data as are available. The figures are, as I have said, essentially incomplete and too much faith should not be placed in their accuracy. It is highly desirable that the statistics which have still to be compiled shall have a much higher degree of uniformity in order that the findings of various studies may be combined and compared. It is for that reason that I have made a special point of stressing the recommendations of the Committee on Statistics of the Blind, which set a pattern for minimum standards, and can be expanded further as experience shows this to be necessary.

Throughout the country there is a renewed interest in the problems of the blind and of prevention of blindness due in part to the expanding of state budgets through federal grants. This seems to offer hope that we may reach our objective—a complete analysis of each case of blindness, to the end that each shall have adequate examination and treatment necessary to give maximum possible vision, and an adequate summary of facts concerning all cases of blindness.

PROTECTION OF CHILDREN FIRST AIM OF FEDERAL CAUSTIC POISON ACT

Fines were recently assessed against a number of manufacturers and distributors, including ten druggists and paint dealers, in the District of Columbia, for selling caustic or corrosive materials in containers which did not meet the labeling requirements of the Federal Caustic Poison Act, report officials of the Food and Drug Administration, United States Department of Agriculture.

Such common household articles as lye, used in softening water, cleaning out drains and kitchen sinks, or ammonia used in cleaning, are dangerous poisons and by law must be labeled as such. Children cannot be expected to read such labels. The products should invariably be stored in a safe place and especially should be kept well out of the reach of children.

Two recent examples of such poisoning have been widely publicized. A small boy in Chicago and another in Washington, D. C., each swallowed lye enough to sear the tissues of the throat and esophagus or gullet, until death by starvation appeared certain because the walls of the passage were healing shut. Both are on the road to recovery as treatment—in one case with a string of small rubber balls, and in the other with a string of small beads—is gradually opening the scarred tissues of the throat as the boys swallow the beads and rubber balls each day. By withdrawing the swallowed objects the physicians are keeping the passages open and are gradually enlarging them as they heal.

Through the efforts of the American Medical Association and other interested persons and organizations, Congress passed the Federal Caustic Poison Act on March 4, 1927, for the purpose of insuring the use of poison labels on the dangerous products and thus putting users on their guard. Enforcement of the Act was assigned to the Food and Drug Administration.

The law applies to the following substances in the percentages noted, or more: Hydrochloric acid, 10 per cent; sulphuric acid, 10 per cent; nitric acid, 5 per cent; carbolic acid, 5 per cent; oxalic acid, 10 per cent; any salt of oxalic acid, 10 per cent; acetic acid, 20 per cent; hypochlorous acid or its salts, except chlorinated lime to yield available chlorine, 10 per cent; potassium hydroxid, 10 per cent; sodium hydroxid (caustic soda and lye) 10 per cent; silver nitrate, 5 per cent; and ammonia water, 5 per cent.

There are four distinct markings which must appear conspicuously on the label to meet the specifications of the Act. They are as follows:

1. The word "poison" must be printed in uncondensed Gothic capital letters. These letters must be at least one-third of an inch high if the trade name or any other word on the label contains a letter this large. If there is no letter this large, the "poison" must not be smaller than the largest letter.

2. Directions for treatment of the poisonous substance must be stated on the label. The Food and Drug Ad-

ministration has published antidotal treatments for each of the twelve caustic or corrosive substances covered by the Act. They are intended primarily to relieve the patient until a physician arrives to administer more thorough treatment, if necessary.

3. The common name of the caustic or corrosive substance must be printed on the label. This not only is informative for those who use it in the home, but it is of particular value to the physician, as he can give immediate medical attention.

4. The label also shall bear the name and place of business of the manufacturer, packer, seller, or distributor.

Legal labeling, officials of the Food and Drug Administration feel, will serve as a caution for parents in storing such poisonous substances out of reach of small children. A small child has little sense of taste and is likely to put into his mouth anything that he can get into his hands.

The cases against the ten druggists and paint dealers in the District of Columbia were based on sales of oxalic acid, acetic acid, and ammonia water, without the labeling required by the law. The cases were first offenses on the part of the defendants, and apparently for this reason the court, after each had entered a plea of guilty, imposed a nominal fine of \$10 in each case. The statute provides for a fine of not more than \$200 or imprisonment for not more than ninety days, or both.

SOCIAL WORKERS PLAN UNION*

The first trade-union of social workers ever set up in the United States will shortly be organized in New York under a charter from the American Federation of Labor.

The move represents a decision by the Federation to create like unions in other cities and, eventually an international union. For the present, the New York union and others that may be set up in other cities will operate as federal locals, directly affiliated with the Federation and subject to a measure of control by the parent body.

FOLLOW PRACTICE

This follows the fifty-year practice of the Federation in first organizing local unions more or less in leading strings until a sufficient number have been organized to permit the setting up of an international union with full and complete autonomy.

William Collins, general organizer of the Federation in charge of the New York area, who did the pioneer work of organizing the automobile workers of Detroit, while admitting that plans for organizing New York are well under way, declined to go into details, saying:

"There is considerable yet to be done. But is there any reason why these people should not be organized and in the Federation?"

RECOGNIZES CONDITION

The decision of the Federation to organized social workers is a recognition of changed conditions, persons intimate with the practices of the Federation said.

Hitherto, the Federation has not considered the social worker organizable material, and the social worker, usually pretty much of a lone worker, has not looked with kindly eye on organization, and especially under American Federation of Labor auspices. Such organizations as they have had have been more in the nature of clubs and social organizations than unions.

NEED APPARENT

During the depression, however, when social work expanded into almost an industry, the need of organization became more apparent. On the part of the labor leaders, with whom the social workers came into much more intimate contact than before, old prejudices vanished, and their place in the labor movement became apparent.

There are several organizations of social workers now in Greater New York, each working independently of each other. It is expected that most of these will merge with the new union.

* From a news dispatch by John J. Leary, Jr., in the *Los Angeles Examiner*.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. X, No. 1, January, 1912

From Some Editorial Notes:

The Second Decade.—The year 1912 brings to a close the first decade in the life of the reorganized State Society, and also of the *California State Journal of Medicine*. Some of the years—particularly the early ones—were, to put it mildly, stormy; bad weather was the prevailing condition. So many things happened, so uphill was the work and so constantly did the stones for building roll down hill a bit upon the slightest provocation, that one thought came to be the regular daily opening of consciousness: "What will happen next?" The question did not arise, "Are we in debt?" It was always, "How much do we owe?" The early years were indeed rough and stormy. We were fighting for the promotion of a few truths, and to get any truth disseminated demands repetition, reiteration—hammering home. In the hammering process, someone would occasionally get hurt; libel suits in plenty were threatened; a few were actually filed; none ever came to trial. With the close of the decade we find a great change; comparative quiet has followed the storm, though occasionally there is a little disturbance; we no longer ask, "How much do we owe?" but with confidence say, "What is the bank balance today?" That helps a good deal! But because the Society is in good condition and fairly prosperous, let us not for a moment think that the work is done. The foundation of the building is built fairly strong; now let us, during the next decade, see that the good, solid building operations continue; let us continue the work until we have a really complete and thoroughly well-built State Society; one that is so strong, so valuable to its members, so active and so continuously alive to their interests and for the public welfare, that no practicing physician in the State can afford *not* to be a member. . . .

By His Work.—Elsewhere in this issue of the journal will be found a résumé or abstract of some documents published as Bulletin No. 22 of the Los Angeles County Medical Association. Senator Works, the distinguished Eddyite representative in the United States Senate, took several hours of the nation's time to address the Senate more or less on the subject of his health, that of his wife, and the health and habits of his son, the inefficiency of "regular" doctors. . . .

Extra-Medical Proselyting.—In these days when publicity on large questions seems to be the tendency of the hour, it is of great interest to the medical world to note that trend, in so far as it affects medical affairs. Our profession and medical considerations in general have certainly not suffered from lack of the calcium ion which illuminates. Doctor Wiley, "Christian Science," the Owen bill, tuberculosis work, vivisection, etc., are very much battered subjects, and our own good Senator Works (not Senator Good Works) has had a pretty bit of notoriety thrust upon him by his tampering. All these mental pabula, however, have been served without anything to make them savory, until of late there have appeared from the pen of a brilliant Frenchman, Brioux, two plays which deal with hot coals, these burning subjects being the problem of artificial abortion, and our old friend, syphilis. One play is called "Maternité," the other "Les Avaries," or, as Mrs. Bernard Shaw has translated them, "Maternity," and "Damaged Goods." . . .

A mere recital of the stories seems bald and unspeakably ugly, but the author has employed an artistry born of genius, and the plays are achieving a tremendous vogue abroad. Here at last we have some medical matters brought to our notice in a form more compelling to the

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BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

News Items

"Healers of every sect, physicians, osteopaths, chiropractors, and all the rest are taking a basic science examination in Arizona under a law recently passed. The medical doctor is not examined on medicine nor the chiropractor on chiropractic, but both are required to show what they know about the structure and processes of the body on which they practice. They are examined on anatomy, bacteriology, chemistry, hygiene, physiology, and pathology. There are no sects on any of these sciences. The muscles and bones are in the same places and chemical processes react in the same way, whether one is a physician or a naprapath. But if one is to deal professionally with these structures and processes, by whatever theory, he should know where and what they are and how they work, normally and abnormally. We require that knowledge in one who operates or repairs engines; it is at least equally indispensable to one who undertakes the same responsibilities with living human bodies. Mental healers, by this law, are exempt. Since they treat abdominal pain by appealing to the mind, it is not necessary for them to know where the stomach and the appendix are, or to be able to distinguish which one of them it is that hurts. It would seem that this requirement is the very least which the State owes, for the protection of its citizens against ignorance. So long as there are persons who believe that there are sects, in the art of healing, the law must recognize those sects and permit all qualified persons to practice them. But that qualification is based on these basic sciences, without which a practitioner would be like an automobile mechanic who did not know that the cylinder contained pistons which were operated by the explosion by electric spark of gasoline vapor and air. Mere fidelity to a theory is no substitute for information and no mitigation of ignorance. The Arizona experiment will be followed with interest." (San Francisco Chronicle, December 16, 1936.)

"Continuing their Pacific Coast clean-up of syndicates and persons conducting fraudulent enterprises through the mails, United States postal inspectors at Los Angeles last night announced arrest of Lewis Levy, charged in a Wisconsin indictment with participating in a variation of the 'eyesight racket.' Federal men said a group with which Levy was connected guaranteed to remove cataracts from patients' eyes at fees ranging from \$500 to \$1,000. The 'medical' group's headquarters is at Milwaukee. Levy was held in \$15,000 bond, pending removal proceedings." (Sacramento Union, December 7, 1936.)

"Two women, charged with aiding illegal operations as members of a coast-wide ring recently shattered by indictment of thirty-one persons, won clemency before Superior Judge Steiger yesterday. The pair, Mary Wilson and Leola Habel, were allowed to plead guilty to a misdemeanor carrying a sentence of less than a year in the county jail, and a hearing of their plea for probation was set for December 8. The court also quashed fourteen of thirty-one indictments returned here against doctors and civilians connected with the ring which functioned also in Los Angeles, Long Beach, Hollywood, and San Diego. The nullification of the indictments was requested by John McMahon, Assistant District Attorney, on grounds defendants have been tried at Los Angeles. In discussing the break-up of the ring, McMahon said: 'The main violators have gone to San Quentin, or are on their way, for ten to twenty-five years. There have been eleven convictions in Los Angeles, headquarters of the group. Twelve cases were dropped due to insufficient evidence.'

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† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

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- Wilson, Lillian, Oakland, Nurse
See Pacific Coast abortion racket
Indicted June 18, 1936, by San Francisco Grand Jury (July, 1936), p. 112
Indicted by Los Angeles Grand Jury (September, 1936), Adv. p. 23
Convicted by jury October 24, 1936 (December, 1936), Adv. p. 24
Sentenced November 16, 1936, to five years' probation, including six months in the Los Angeles County jail
- Wilson, Mary, Oakland, Nurse
See Pacific Coast abortion racket
Indicted June 18, 1936, by San Francisco Grand Jury (July, 1936), p. 112
- Witnesses for Prosecution
See Pacific Coast Abortion Ring
Buffum, Roy L., M.D.
de Gaston, Paul
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Powers, William Norman, M.D.
Reithel, Marvin
Tatem, H. N., D.C.
Tieman, Bernice
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- Wyatt, Thomas D., M.D.
See hearings
Witness refuses to testify before Board (December, 1936), Adv. p. 27
Hearing continued (December, 1936), p. 520
- Wyman, George H., M.D.
Brought into court on abortion charge (July, 1936), Adv. p. 18
Guilty, June 25, 1936 (August, 1936), Adv. p. 18
License revoked October 21, 1936 (December, 1936), Adv. p. 520
- Zoffell, Frances
Arrested San Francisco Abortion (August, 1936), Adv. p. 18
- Zoffell, Raymond
Arrested, McAllister Street, San Francisco, abortion (August, 1936), Adv. p. 18 (September, 1936), Adv. p. 18
- Zoffell, William
Arrested San Francisco Abortion (August, 1936), Adv. p. 18; (September, 1936), Adv. p. 18
- Zorb, George Anthony, M.D.
Wins reversal of \$20,000 judgment rendered Dr. Clair Wilson by Superior Court (October, 1936), Adv. p. 23



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These terminations were entered in cases involving medicinal preparations: Chicago Drug Sales Company, Chicago, Illinois, six seriously misbranded and adulterated patent medicines obtained principally through "salvage" operations, fine, \$25; John W. White, proprietor of White Herb Manufacturing and Remedy Company, Bessemer, Alabama, "White's Herb Tonic Compound," consisting of plant extracts in water and less than one-tenth of one per cent alcohol, offered for the treatment of stomach complaints, liver and kidney ailments, and indigestion, fine, \$300, six months' jail sentence suspended and defendant placed on probation for five years; Poloris Company, Inc., New York, N. Y., "Poloris Dental Poultice," containing belladonna leaves, hops, aconite, sassafras, and acacia, for the treatment of toothache, abscess, swelling or inflammation of the gums, gingivitis, and trench mouth, fine, \$125; Holford Company, Minneapolis, Minnesota, "Holford's Famous Inhaler," containing lavender flowers, mustard seed and oil of mustard, offered for the treatment of catarrh, headaches, asthma, hay fever, sinus trouble, cold in the lungs, sore throat, constant coughing, tonsillitis, toothaches, neuralgia, and fainting spells, fine, \$100; Erie Drug Company, Erie, Pennsylvania, an imitation vanilla flavor not labeled to show its imitation character, a "germ killer" found to be not germicidal when used as directed, and ten patent medicines variously represented as treatments for coughs, catarrh, croup, ulcers, skin diseases, rheumatism, cramps, backache, blood, liver, kidney and bladder disorders, erysipelas, dyspepsia, neuralgia, diabetes, grippe, hysteria, pneumonia, whooping cough, eczema, and pleurisy, fine, \$50 and costs; Timlake Products, Inc. (Henry F. J. Lake, President), Des Moines, Iowa, "Blu-V-Spray" and "Germite Wormer," fraudulently offered for the treatment of infectious diseases and worms in poultry, fine,

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\$75 and costs; and Certified Laboratory Products, Ltd., San Francisco, impure nitrous oxide (laughing gas), fine, \$20. . . .

A survey of absorbent cotton, gauze bandages and similar products, generally represented to the purchaser as "sterile," has shown that many of these items are not free from bacteria, the Food and Drug Administration reports. Seizures were effected during the month of the following goods, on charges of interstility: 1,500 packages of absorbent cotton, 2,880 packages of gauze bandage, 5,000 gauze pads, and 35 first-aid kits containing absorbent cotton and gauze bandages. One lot of glucose-calcium ampoules, unsterile and low in calcium, was also seized.

Medicinals seized during October included 240 gallons of substandard cod-liver oil; 900 pounds of "De-Raef Milk Mineral Salts," consisting, despite the name, of 90 per cent corn sugar with small quantities of salt, magnesium and calcium compounds, and rennet; "Antiseptol," a mixture of boric acid, zinc sulphate and menthol, represented as antiseptic although having no antiseptic effect when used as directed, offered for the treatment of women's ailments; "Bell's Veterinary Medical Wonder," containing 63 per cent alcohol (the label stated 40 per cent alcohol), and plant drugs including alkaloids and resins, and flavoring, offered for colic, coughs, chills, refusal to eat, uneasiness, nervousness, exhaustion, abdominal pains, bloating, staggers, pleurisy, bronchitis, distemper, azoturia, garget, catarrh, and other ailments of horses, cattle, sheep, hogs, dogs, and poultry; "Kayan," containing phenolphthalein 1.2 grains per teaspoonful, gum, sugar, and starch, represented as the "granulated powder from the sap of an Asiatic tree," and although the product was itself only a cathartic and purgative, its label carried these statements: "pills, cathartics, and purgatives do more harm than good," "remarkable discovery," "new hope and health for millions," and "sweeps the poisons out of the intestines like a new broom cleans a room"; "Lane's Pills," containing calomel, a plant laxative, sugar, ferrous carbonate, and strychnin, for liver

(Continued on Page 41)



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(Continued from Page 39)

troubles, headaches, indigestion, dizziness; "Lane's Tea—the Family Medicine," a mixture of crude drugs, insect-infested, offered for faulty elimination; "Nash's Carbolic Salve," consisting of petrolatum, carbolic acid, camphor, resin, and boric acid, whereas carbolic salve should contain only carbolic acid, yellow wax, and petrolatum, not antiseptic as claimed, and offered for the treatment of cuts, salt rheum, tetter, eczema, fever, sores, boils, felons, and pimples; "Nash's Pain-Go," kerosene, and volatile oils, including oil of turpentine and oil of sassafras, falsely represented as antiseptic, for pains, rheumatism, toothache, bunions, headache, lumbago, sore throat, stiff joints, and sore feet; "Nox-a-Boil," pills containing iron, calcium, and magnesium carbonates, phosphates, sulphates and chlorids, talc, sugar, starch, and fat, for boils, pimples, carbuncles, tonsillitis, sore throat, canker sores, discharging ears, infected wounds, septic infections, sprains, bruises, ulcerated teeth, abscesses, and inflammation; "Runner's Combined Eczema Lotion and Remedy for the Skin and Scalp," consisting of glycerin, water, boric acid, and small amounts of salicylic acid, wintergreen, and carbolic acid, for eczema, barber's itch, ringworm, tetter, salt rheum, pimples, ivy and oak poisoning, to allay itching and reduce inflammation; and "Seedol Kelpamalt Tablets," consisting of kelp (a sea weed), cocoa, sugar, salt, and saccharin, but no malt diastase although its presence was indicated by the label, and accompanied by a bookful of unsubstantiable claims of benefit in mineral and vitamin deficiencies, weight control, appetite improvement, constipation, and other conditions.

Modified United States Regulation on Dog and Cat Food in Effect.—Recent developments in the commercial preparation of dog food, cat food, and similar products have caused the Bureau of Animal Industry, United States Department of Agriculture, to modify its regulations pertaining to these products. Designated as Amendment 10 to B. A. I. Order 211, the new requirements provide for the withdrawal of the familiar meat-inspection stamp from containers of dog food and similar products. The new regulation provides, however, that containers of such products may bear the statement, "The meat or meat by-product ingredient of this article has been examined and passed under federal supervision. This article has been prepared in an establishment operating under federal meat inspection."

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The regulation, now in effect, also provides that the regular meat-inspection legend as used on food intended for human consumption may not be used on food designated as being intended for dogs, cats, foxes, and similar

(Continued on page 44)



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(Continued from Page 41)

animals. Thus, the inspection legend, "U. S. Inspected and Passed by the Department of Agriculture," is reserved exclusively for foods intended for human consumption.

The essential purpose of the new amendment is to inform the public that the meat ingredient has been inspected and passed, but that inspection has not included various other ingredients with which the meat has been combined.

The amendment further provides that when dog food or like articles are prepared in a part of a federally inspected establishment, its sanitation shall receive the same supervision as other parts of the establishment.

Details concerning the bureau's supervision of dog food and like products and their proper labeling are set forth in an official notice to supervising inspectors and proprietors and operators of establishments where such products are prepared. The Department of Agriculture also has arranged to receive reports to be used for statistical purposes relating to the commercial output of this class of product.

Teachers: Are These Suggestions Worth While?—

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3. If you exercise regularly, you will stimulate your metabolism and the function of all your vital organs.
4. If you establish correct eating habits, avoiding irregularity of meals and "food fads," you will prevent illness.
5. If you maintain good elimination, you will get rid of harmful toxins and ward off serious ailments.

6. If you stay at home in bed when you have an acute infection, you will save your own health and avoid spreading disease.

7. If you take showers, tempered to your individual reaction, every morning instead of indulging in too many hot baths, you will increase your resistance.

8. Reflect in your actions how happy you are to be well and not crippled or suffering pain from chronic disease; for children's health and happiness depend a great deal on your attitude toward them and toward life in general.

9. Your pupils imitate *you* and if you are kind, generous, courageous, and upright, you may do more good in building up the children's characters than many lectures would do.

10. A teacher, by her behavior, may become the great ideal toward which her children are striving, influencing their entire lives and characters.

11. Visit your family doctor once a year for a general check-up. You check your car for defects, why not check your own machinery, which is far more important than your automobile. A check-up once a year may prevent a very serious chronic disease, may prevent years of suffering and dependence.—Sven Lokrantz, M. D. (Los Angeles City School District, Health Section).

So long as the interests of the public health are guarded and advanced, the interests of the medical profession will follow. In other words, the interests of the health of our citizens and the interests of the medical professions are inseparable.—Ralph M. Carter, M. D., President, State Medical Society of Wisconsin.

Yet all experience is an arch where through
Gleams that untraveled world whose margin fades
Forever and forever when I move.

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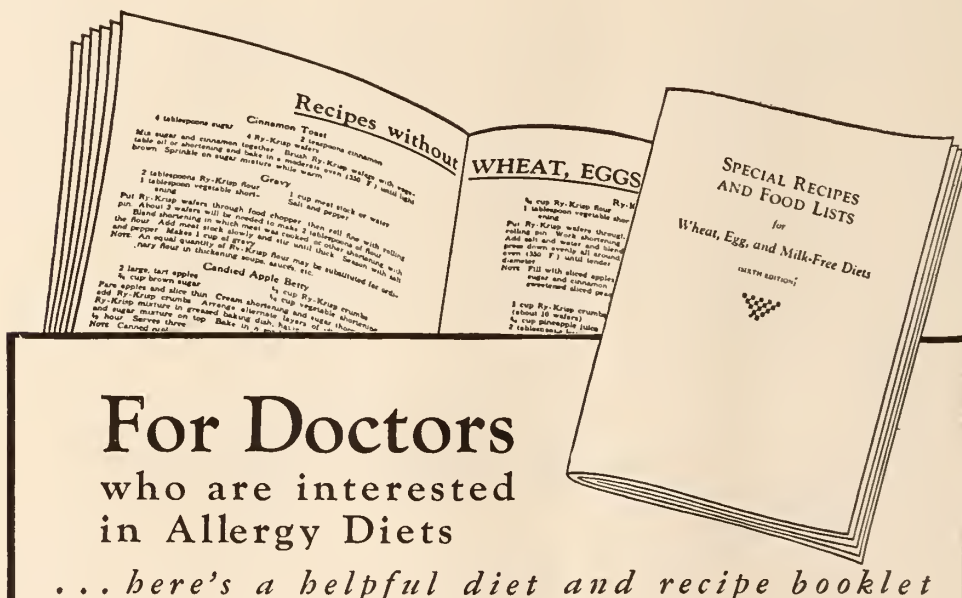
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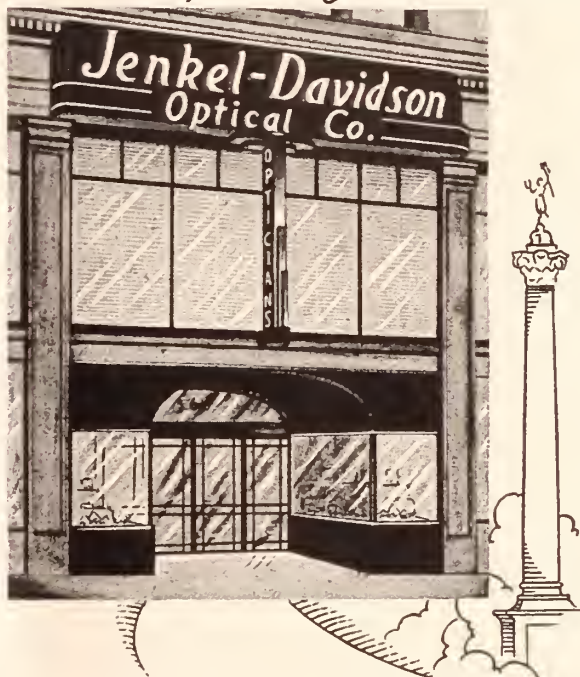
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Secretary, Thomas A. Card, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Raymond M. Wallerius, 312 Physicians Building, Sacramento.
Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, L. C. Hull, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, D. C. Mock, 215 Cajon Street, Redlands.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego
President, S. J. McClendon, 2001 Fourth Street, San Diego.
Secretary, W. H. Newman, Medico-Dental Building, San Diego.
Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, T. Henshaw Kelly, 490 Post Street, San Francisco.
Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.
Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, John S. Blinn, 1101 Medico-Dental Building, Stockton.
Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Charles R. Kennedy, Bank of America Building, Paso Robles.
Secretary, E. D. Anderson, 1120 Morro Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Mulholland's Grill, San Luis Obispo.*
(Roster lists continued on advertising page 6)

San Mateo County Medical Society
President, Frank S. Gregory, 736 Main Street, Redwood City.
Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Irving Wills, 1421 State Building, Santa Barbara.
Secretary, William H. Eaton, 822 De la Guerra Terrace, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, R. Stanley Kneeshaw, 404 Medico-Dental Building, San Jose.
Secretary, Leslie B. Magoon, Medico-Dental Building, San Jose.
Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society
President, A. N. Nittler, 36½ Pacific Avenue, Santa Cruz.
Secretary, Samuel B. Randall, Farmers and Merchants Bank Building, Santa Cruz.
Meeting, *Second Tuesday, 7:30 p. m., Hotel Rio del Mar, Aptos.*

Shasta County Medical Society
President, Oscar J. Hansen, 318 Yuba Street, Redding.
Secretary, Leslie J. Seeley, 1432 York Street, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, E. F. Carlson, Fort Jones.
Secretary, J. B. Maguire, Mt. Shasta City.
Meeting, *Second Sunday.*

Solano County Medical Society
President, H. Brownlie Perkins, 445 Georgia Street, Vallejo.
Secretary, John W. Green, Box 539, Vallejo.
Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, C. B. Andrews, Sonoma.
Secretary, C. M. Carlson, 1055 Fourth Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Marion C. Collins, Turlock.
Secretary, Edwin F. Hagedorn, Box 834, Modesto.
Meeting, *Second Friday.*

Tehama County Medical Society
President, Donald E. Thompson, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, J. C. McClure, Lindsay.
Secretary, Karl F. Weiss, Security First National Bank Building, Visalia.
Meeting, *Sunday Evening once a month.*

Ventura County Medical Society
President, F. R. Hendricks, 885 East Main Street, Ventura.
Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society
President, Stanley E. Coffey, 239 Fourth Street, Orland.
Secretary, Ray E. Nichols, Woodland.
Meeting, *First Tuesday.*

Yuba-Sutter County Medical Society
President, Stanley R. Parkinson, 434 Fourth Street, Marysville.
Secretary, Fred W. Didier, Wheatland.
Meeting, *Second Tuesday.*

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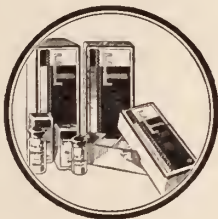
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Not infrequently a striking result in serum therapy has been observed in atypical pneumonia considered not pneumococcal before the type was determined.

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Vision in College Students.—Obtaining a college education involves a definite strain on eyesight for many students, it was pointed out by Dr. Ruth E. Boynton of Minneapolis, in an address before the annual conference of the National Society for the Prevention of Blindness in Columbus, Ohio, recently. Doctor Boynton is associate professor of preventive medicine and public health at the University of Minnesota and director of the Students' Health Service for the University.

Reporting on a study of the changes in vision which took place among one thousand students during their four years at the University of Minnesota, Doctor Boynton said that about one in six of those entering college had seriously defective vision, but the percentage increased to about one in four by the time they were graduated. Most of these students were enrolled in the Medical School or the College of Education. She said that, upon entering the University, 52 per cent had normal vision, 18 per cent had serious defects in vision, and 30 per cent had slight defects in vision. At the time of graduation, however, eye examinations disclosed that 24 per cent had seriously defective vision.

Doctor Boynton observed that "students having the lowest visual acuity when entering the University had the most marked decrease in vision at the end of four years." She reported also that myopia, commonly known as nearsightedness, is apparently less of a handicap than either farsightedness or astigmatism, since a large percentage of nearsighted students were among those with the highest scholastic ranking.

"Stone walls do not a prison make
Nor iron bars a cage."

Winter is a jailer who shuts us all in from the fullest vitamin D value of sunlight. The baby becomes virtually a prisoner in several senses: First of all, meteorologic observations prove that winter sunshine in most sections of the country averages 10 to 50 per cent less than summer sunshine. Secondly, the quality of the available sunshine is inferior due to the shorter distance of the sun from the earth, altering the angle of the sun's rays. Again,

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POSTGRADUATE instruction offered in all branches of medicine. Special courses are offered in certain subjects. Courses leading to a higher degree are also given.

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Graduate School of Medicine
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the hour of the day has an important bearing: At 8:30 a. m. there is an average loss of over 31 per cent, and at 3:30 p. m. over 21 per cent.

Furthermore, at this season the mother is likely to bundle her baby to keep it warm, shutting out the sun from Baby's skin; and in turning the carriage away from the wind she may also turn the child's face away from the sun.

Moreover, as Dr. Alfred F. Hess has pointed out, "it has never been determined whether the skin of individuals varies in its content of ergosterol" (synthesized by the sun's rays into vitamin D) "or, again, whether this factor is equally distributed throughout the surface of the body."

While neither Mead's Oleum Percomorphum nor Mead's Cod Liver Oil Fortified With Percomorph Liver Oil constitutes a substitute for sunshine, they do offer an effective, controllable supplement, especially important because the only natural foodstuff that contains appreciable quantities of vitamin D is egg-yolk.

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The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

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CANYON SANATORIUM For the Treatment of Tuberculosis Redwood City, California	LAS ENCINAS SANITARIUM Nervous and General Diseases Las Encinas, Pasadena, California	SAINT FRANCIS HOSPITAL Limited General Hospital Bush and Hyde Streets, San Francisco
COLFAX SCHOOL FOR THE TUBERCULOUS For the Treatment of Tuberculosis Colfax, California	LIVERMORE SANITARIUM Nervous and General Diseases Livermore, California	ST. LUKE'S HOSPITAL Limited General Hospital 27th and Valencia Streets, San Francisco
COMPTON SANATORIUM AND LAS CAMPANAS HOSPITAL Neuropsychiatric and General Compton, California	OAKS SANITARIUM For Treatment of Tuberculosis Los Gatos, California	ST. MARY'S HOSPITAL General Hospital 2200 Hayes Street, San Francisco
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treatments

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Ten Principles in Health Teaching.—1. We must teach the body as a whole rather than as a collection of anatomical and physiological systems.

2. We must attempt to create in the mind of the child a vast admiration for the body and its various processes.

3. We must bring out the point in every possible instance that health and disease are the results of adequate cause, and that there is nothing of the supernatural or adventitious in the various processes involved.

4. We must make the health program a happy one. Beauty, grace, strength, endurance, and efficiency must take the place of the opposite qualities as motivating agents.

5. We must make the subject interesting else it will be boring and soon forgotten.

6. We must teach living rather than the technique of living. Hygiene must throb with life; it must be vital and to the point so that it will meet the problems of life.

7. We must teach hygiene in relation to the procession of life that reaches back to the day of creation. The human species bears certain relations to heredity and environment which are essentially the same as those of other living things and are best understood by a study of lower forms.

8. We must teach, on the other hand, that the human species has also a higher destiny and that there are considerations of morals, esthetics, ethics, social relations and responsibilities, culture and civilization, which have no counterpart in the lives of lower forms.

9. We must teach health as a means to a higher end and not as an end in itself.

10. We must somehow make the child understand that life is adaptable—that life finds a way—that life grows and develops.—Thurman B. Rice, M.D., in *Indiana Health Bulletin*.

Man cannot degrade woman without himself falling into degradation; he cannot elevate her without at the same time elevating himself.—Alexander Walker.

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BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

Synopsis of Anorectal Diseases. By Louis J. Hirschman, M. D., F. A. C. S., Former Vice-President, American Medical Association; Former Chairman, Section on Gastro-Enterology and Proctology, American Medical Association; Former President, American Proctologic Society; Professor of Proctology, Wayne University; Fellow (Honorary) Royal Society of Medicine, etc. Cloth. Pp. 288, with 174 text illustrations and six color plates. Price, \$3.50. St. Louis: The C. V. Mosby Company, 1937.

Physical Therapeutic Methods in Otolaryngology. By Abraham R. Hollender, M. D., F. A. C. S., Associate in Laryngology, Rhinology, and Otolaryngology, University of Illinois College of Medicine; Fellow of the American Academy of Ophthalmology and Otolaryngology. Cloth. Pp. 442, with 189 illustrations. Price, \$5. St. Louis: The C. V. Mosby Company, 1937.

The Management of Obstetric Difficulties. By Paul Titus, M. D., Obstetrician and Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; Consulting Obstetrician and Gynecologist to the Pittsburgh City Homes and Hospital, Mayview, and to the Homestead Hospital, Homestead, Pennsylvania; Secretary of the American Board of Obstetrics and Gynecology. Cloth. Pp. 879, with 314 illustrations, including four color plates. Price, \$8.50. St. Louis: The C. V. Mosby Company, 1937.

On Your Guard! The Prevention and Treatment of Sex Diseases. By Carl Warren, B. A., B. S., M. S. J., Advised and Assisted by Eminent Specializing Physicians. Foreword by M. J. Exner, M. D., Director of Educational Department and Consulting Physician of American Social Hygiene Association; Director of Sexual Education, International Committee, Y. M. C. A.; in Charge of Social Hygiene Education for United States Army during World War. Frontispiece and illustrations by C. D. Batchelor. Cloth. Pp. 160. Price, \$1. New York: Emerson Books, Inc., 1937.

Proceedings of the Thirtieth Annual Convention of the Association of Life Insurance Presidents. Held in the Waldorf-Astoria, New York City, December 3 and 4, 1936. Paper. Pp. 251. Printed in the United States.

BOOK REVIEWS

The Management of Obstetric Difficulties. By Paul Titus, M. D., Pittsburgh. Pp. 879, with 314 illustrations. Price, \$8.50. C. V. Mosby Company.

Obstetrical emergencies must be met promptly because of their nature and because delay or expectancy increases mortality and morbidity. Titus has written this text on obstetrical difficulties and emergencies for the general practitioner who accepts obstetrical cases. Specialists will find it to be an addition to their libraries.

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presents the proper management when such emergencies confront the attending obstetrician.

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(Continued on Next Page)

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BOOK REVIEWS

(Continued from Preceding Page)

presented his own experience and advice. All in all, this is a most worth while contribution, meriting a place on the desk of every general practitioner.

Physical Therapeutic Methods in Otolaryngology. By Abraham R. Hollender, M. D., University of Illinois. Pp. 442, with 189 illustrations. Price, \$5. St. Louis: C. V. Mosby Company.

A review and clinical evaluation of physical therapeutic methods. The main text is devoted to clinical problems. The author describes indications and technique. On the whole, it is a quite satisfactory text for the student and beginner. It is sound in the groundwork that it lays and should guide one to seek extended clinical practical experience.

Synopsis of Anorectal Disease. By Louis J. Hirschman, M. D., Detroit. Pp. 278, with 174 illustrations. Price, \$3.50. St. Louis: C. V. Mosby Company.

After having written an accredited textbook on the same subject, it is difficult to find any reason as to why Hirschman should desire to put out this synopsis. It is a synopsis only, with many important details omitted. Good as far as it goes, but lack of completeness prohibits approval and recommendation. Detailed review space is not warranted.

On Your Guard: The Prevention and Treatment of Sex Diseases. By Carl Warren, B. A., B. S., M. S. J. Pp. 160. Price, \$1. New York: Emerson Bros., Inc.

An informative, reliable book on venereal infections, addressed to the lay public. Can be recommended to those seeking dependable information.

It is a great cleverness to know how to conceal our cleverness.—Rochefoucauld.

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(Continued from Text Page 144)

society. *A member suspended for unpaid and overdue dues is not in good standing.*

Fifth: Any member who may be served with any papers in any suit must send the original papers or a true and exact copy of them to the secretary of the State Society *within two days*. In all such suits ten days are allowed in which to file an answer, so that ample time is allowed our attorney to take up the matter of defending the suit.

Sixth: As soon as possible after sending in the papers, the defendant member shall send to the secretary a full account of the case, diagnosis, treatment, etc., which statement, together with the other papers in the case, will be placed in the hands of our attorney immediately.

♦ ♦ ♦

Doctor Wiley.—There are so many "glooms" in the work-day world that it is a blessing when a few "joys" come along and put them to rout. Also, thank the Lord for a sense of humor! Since the crafty plot to discredit Doctor Wiley and practically put an end to the enforcement of the Pure Food and Drugs law failed, various and sundry trade journals have been full of the bitterest sort of editorial matter relating to the incident and attacking Doctor Wiley. . . .

♦ ♦ ♦

Surgeon-General Rupert Blue.—Distinctly gratifying to the profession of this State must be Doctor Blue's appointment by President Taft to the post of Surgeon-General of the United States Public Health and Marine Hospital Service, and in commenting upon this promotion we not only heartily congratulate the doctor, but just as heartily the country. Rupert Blue has on past occasions been publicly and privately deluged with the thanks of California, and particularly San Francisco, for his monu-

(Continued on Page 17)



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So emphatic were these favorable opinions that we cannot but feel that Benzedrine Inhaler has won the good will of the medical profession to a surprising degree. The busy physician seems to be genuinely grateful for its immediate effectiveness, its convenience—and the fact that it is handy for use at *any* time and in *any* place.

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Each tube is packed with benzyl methyl carbinamine, .325 gm.; oil of lavender, .097 gm.; and menthol, .032 gm. "Benzedrine" is the registered trade mark for Smith, Kline & French Laboratories' brand of benzyl methyl carbinamine.



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cation goes far toward insuring the comfort and co-operation of your patients.

Being volatile, Benzedrine penetrates to areas not readily accessible to liquid inhalants, promptly reducing engorgement wherever it exists in the rhinological tract. And, by re-establishing drainage of the accessory sinuses, it may often help to prevent acute attacks from becoming chronic.

Prolonged use of the inhaler does not tend to produce tolerance or atony.

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.—EST. 1841

CASE HISTORY: T. A. Male, white, age 27. Acute exacerbation of a chronic sinus infection.

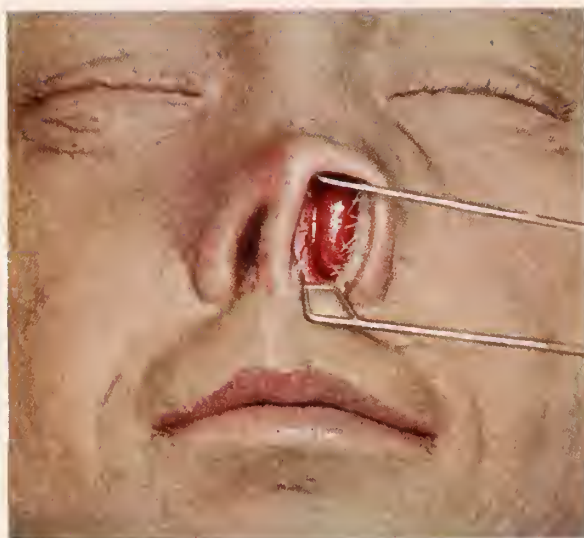


FIG. 1. 2:35 P.M. Before treatment.



FIG. 2. 2:57 P.M. After using Benzedrine Inhaler. Drainage established.

BENZEDRINE INHALER



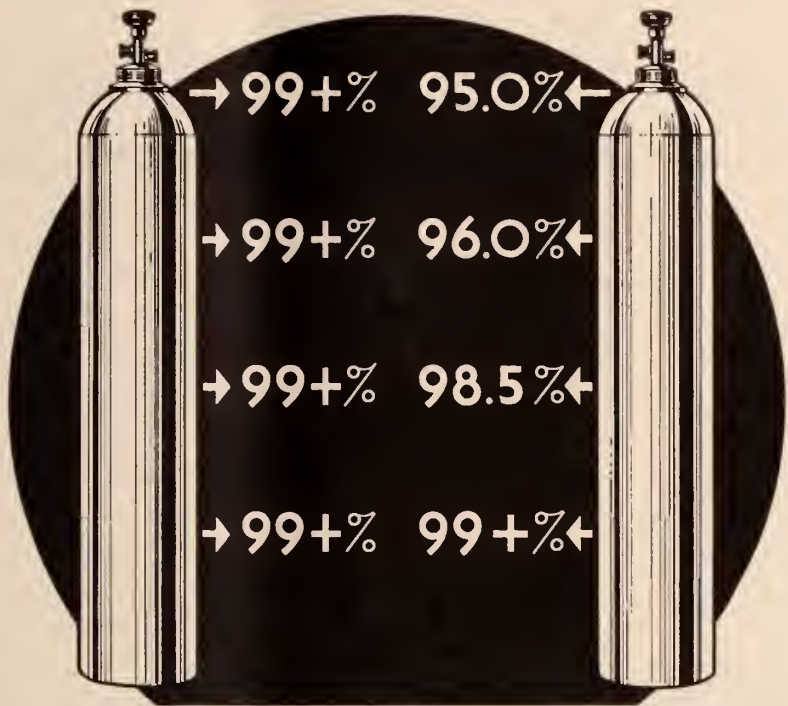
TWENTY-FIVE YEARS AGO

(Continued from Page 14)

mentally efficient labors in his sanitation work out here, and it is not our purpose to embarrass him with another saccharin effusion. . . .

1 1 1

Original Articles.—The *Journal* is always glad to receive original articles, whether they have been read before the Society or not. Short reports of clinical cases of general interest are particularly desirable. Illustrations, when they are really necessary to elucidate or really add to the text, will be made at our expense, provided the author furnishes clear and satisfactory drawings or photographs. *Manuscript should never be rolled.* It should be sent flat, between boards, or folded. It must be typewritten to receive consideration. Authors should remember that the compositor, or typesetter, puts into type exactly what he sees before him on the manuscript, unless it is otherwise marked. Look at your manuscript with this fact in mind and picture to yourself what it will look like when put into type exactly as you have written it. It is a very common thing for an author to abbreviate certain words in order to save the trouble of writing them out. They are simple and obvious abbreviations to him, but they are meaningless to the typesetter. Also, they would not infrequently be almost meaningless to any other reader, to say nothing of the fact that a scientific communication is supposed, so far as we are concerned, to be a statement of things in the English Language and not a guessing contest or a puzzle. "Ant. sup." may mean anterior superior to the author, but we would hate to say what it might look to the compositor! Not infrequently otherwise valuable manuscripts have to be returned for this reason. Furthermore, *please* try and spell proper names correctly every time they are used. To find a reference to "Dr. Smith" on one page and to the same man as "Smythe" on another is, to say the least, somewhat confusing; when repeated, with further variations, it has been known to cause violent profanity. Charts, and especially tables when they are at all extended, complex or bulky, are very expensive things to reproduce, and ninety-nine times in a hundred are not half so necessary or important as the author thinks they are. Of course, it is always the editor's fault if an article submitted does not receive publication. No author has ever been known who would admit the slightest reason for withholding publication except the cantankerousness or personal bias of the editor. That seems to be human nature. An author will write: "The matter is so well



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known to you all that it seems hardly necessary to mention it"—and then proceed, for the next few pages, to write out what is "so well known to you all"; and then if this portion of his article is "cut out" he is quite hurt.

These are just a few suggestions with nothing personal about them and no special articles or authors in mind (that is not entirely true). If you will read them over and think about them it will be a great help to (1) yourself, (2) the editor, and (3) the compositor.

1 1 1

Medical Defense.—The following circular letter was prepared by the attorney for the State Society in July, 1909, and a copy was sent to every member of the Society. It was published at least twice in the *Journal*, but it seems wise to publish it again. To the statements made therein it is only necessary to add that the plan has proved to be a complete success. It is no longer an experiment, but

(Continued on Next Page)

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AGENTS

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

an everyday working part of the machinery of the State Society. Do not waste time wondering "if it will work out"; it has worked out; it is a perfect success. . . .

From an article on "Medical Organizations and Conservation of the Public Health"—President's Address at the Annual Meeting of the Los Angeles County Medical Association, December 15, 1911. By W. Jarvis Barlow, M.D., Los Angeles.—Conscious of a high trust and mindful of greater happiness, the men and women of the medical profession have ever stood for the betterment of human conditions. They have accomplished humanitarian work through personal efforts, unselfish actions, overwork, with or without remuneration, visiting the rich and the poor, by constructive work for the relief of suffering through hospitals, dispensaries, health camps, settlements and the several relief organizations in one way or another, to make life easier, healthier and better, and to help a universal need—the prevention of disease. As individuals they stand well and are respected by their neighbors, friends, and the community; but collectively or as an organized body they seem to hold, at the present time, a different and somewhat unpopular position. Honor and appreciation of altruistic endeavor are rarely accorded and should not be expected by those who act from the highest motives. . . .

Proceedings of the San Francisco County Medical Society—Address of Doctor Ophüls, President—Annual Meeting of San Francisco County Medical Society, December 12, 1911.—At the beginning of my presidential address it is my pleasant duty to express my great and most sincere appreciation to the Board of Directors and to the members of the San Francisco County Medical So-

ciety for electing me to fill this most important office in the Society. I shall always look back upon this year with the greatest pleasure in view of the most cordial and effective support given me by the Society at large, more especially by those who undertook the often arduous duties on the different standing and special committees and by the individual members of the Board of Directors, without which splendid support it would have been impossible to accomplish anything. . . .

The question of renting meeting and office rooms from the trustees of Leland Stanford, Jr., University and of our placing our library in the same building, was fully discussed by a special committee, consisting of Drs. W. W. Kerr, Dudley Tait, P. M. Jones, R. L. Porter, and Charles G. Levison. A statement in regard to the matter was submitted to the members of the Society. A large majority of those who answered expressed themselves in favor of the proposal. Replies were received from about two-thirds of the membership. In spite of this expression of opinion, the Board of Directors decided to lay the matter on the table, largely because there seemed to be some fear that the Society was unable to meet the requirements of the contract which was proposed, financially. I believe that the question is not solved finally. The Society needs better accommodations for its meetings, its offices, and for the library. The placing of the two libraries in one building and the creation of a medical center in San Francisco would be of inestimable benefit to the profession. So far as I can see, the necessities of the Society could not be met by any other scheme on more advantageous terms, and I personally am still strongly of the opinion that at some future date the logic of facts will convince even the most conscientious objector, and no doubt an arrangement can then be made which at the same time would satisfy any demands which the Society can justly make and give the profession what it needs—a large collection of medical literature under one roof, administered independently, if you will, to common advantage.

(Continued on Page 20)

CONSERVATION OF ESSENTIAL ELEMENTS IN PROTECTIVE FOODS

II. THE VITAMINS

● Refinement of vitamin assay methods has made practical many quantitative studies which had hitherto been impossible. Employment of these methods has yielded evidence which indicates that many factors may influence the vitamin content of foods which come to the table; in particular, the fruits and vegetables. Variety, maturity, time and temperature of storage after harvesting, and method of preparation, all have been found to affect the ultimate vitamin content of common foods. Several examples of the extent to which certain of these factors operate might well be given.

It has been shown that spinach slowly loses its vitamin C potency even in low temperature storage; at room temperature, one-half of the vitamin C is lost in three days; practically all antiscorbutic potency disappears in seven days (1).

Another report indicates a loss in vitamin C of 78 per cent in spinach stored two days at room temperature and 80 per cent loss in asparagus tips during four days' storage (2).

The vitamin C content of apples is markedly reduced during cold storage: 20 per cent in 4 to 6 months and about 40 per cent in 8 to 10 months (3).

Vitamin A in apples is, however, subject to less destruction than vitamin C during prolonged storage (4).

Prolonged cold storage of pears may result in a loss in the vitamin A and vitamin C content of nearly 50 per cent (5).

Further, solution losses which may occur during cooking vary with the individual product and with the method used in cooking. From 40 to 48 per cent of vitamin C may be lost to the water in which peas are cooked (6).

Vitamin C losses in 12 different vegetables have been reported to vary from 12 per cent in asparagus to 80 per cent in white onions (7).

These data demonstrate the seriousness of solution losses of vitamin C. It is considered probable that other water soluble vitamins are affected in a similar way.

Thus, by the time fruits and vegetables spend some days in transit or storage before reaching the kitchen and are cooked by the usual home method, much of the original vitamin content may have been lost. Little can be done to prevent storage losses when fresh fruits and vegetables are not available from the home garden, but solution losses may in part be overcome by using the cooking water.

Fortunately, in the commercial canning procedure, products are harvested at the optimum stage of maturity and canned immediately, using only a limited quantity of water which is retained in the can. As a result, storage losses of the vitamins are reduced (8), and solution losses may be eliminated by the use of the liquid in which the food is canned.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1936. Food Research 1, 1.
(2) 1936. J. Soc. Chem. Ind. 55, 153T.
(3) 1933. J. Agr. Res. 46, 1039.

(4) 1936. Food Research 1, 121.
(5) 1934. J. Am. Diet. Assn. 10, 217.
(6) 1936. J. Nutrition 12, 285.

(7) 1936. J. Home Econ. 28, 15.
(8) a. 1921. Proc. Soc. Exp. Biol. Med. 18, 164.

b. 1928. Ind. Eng. Chem. 20, 202
c. 1929. Ibid. 21, 347
d. 1932. J. Home Econ. 24, 826

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

I also wish to call the attention of the Society to the existence of a considerable fund for the benefit of its own library. We have in our possession a capital of \$8,000 originally given for relief purposes, which on July 14, 1913, when it will have increased to \$10,000, becomes available for library purposes under the direction of our Board of Directors. . . .

Report of the San Francisco Medical Milk Commission. It is with much pleasure that after five years' connection with the Certified Milk Commission of this Society, I am now able to give you the present report of its progress.

The affairs of the Commission were never more flourishing. Five years ago when we met to organize the Commission, we had the promise of 190 subscribers, each of whom agreed to take a quart of certified milk daily, provided someone could be found who would, on this slender encouragement, be willing to undertake its production. . . .

Report of the Committee on Legislation.—At the last session of the State Legislature various medical bills of all kinds and sorts were introduced in both houses. Bills defining the practice of medicine; providing fines for illegal practitioners; for the appointment of a board on mechanotherapy, and other of even lesser import. These serially met defeat. Realizing that the appointment of any board by the Governor would always appeal to the political mind, Senator Hurd introduced a bill (Senate Bill 875), providing for the appointment of a board of medical examiners by the Governor; also, providing for the issuing of three forms of certificates—one for the practice of medicine and surgery; one for the practice of osteopathy; one for the practice of any other form of medicine—also legalizing the practice of an Oakland quack of thirty-five years' standing in deception. Although we had the best

reason to believe that this bill would never become a law, even though passed by both houses, nevertheless, contrary to our expectations, the Governor signed the Hurd bill and it is now a law of the State. However, the Governor has never taken advantage of the opportunity afforded him to appoint a new board, preferring to allow the board selected by the respective medical societies to continue in office. The law as it now stands is not in accord with the opinion of the profession, and a determined effort must be made at the next regular session of the State Legislature to have it so amended that it will be once more in harmony with the best interests of the public.

Respectfully submitted,

F. B. CARPENTER,
Chairman, Committee on Legislation.

From an article on "Some Remarks on So-Called Automobile Fractures" by W. H. Winterberg, M. D., San Francisco.—The fact that there is much misconception among both the laity and physicians about just what a so-called automobile fracture is and how it is caused, is perhaps excuse enough for bringing before you a subject which has been well worked out and cases of which are becoming less yearly.

When I use the term "automobile fractures"—they are also called chauffeur's fracture, automobile crank fractures—I mean cases of fracture of the lower and usually outer end of the radius caused by the sudden and violent reversal of the starting crank of an automobile—the so-called "kick-back."

Lane Lectures, 1912.—The thirtieth annual course of Lane lectures will be delivered in Lane Hall, Cooper Medical College, beginning Friday evening, January 12, at eight o'clock, and continuing every alternate Friday evening thereafter, until the lectures are given. These lectures are free and no ticket of admission is required. . . .

(Continued on Page 22)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 20)

Sheriff Ullery in 1931." (Yuba City *Independent-Farmer*, January 1, 1937.) Roy L. Martin was prominently featured in the 1930 annual report of the Board of Medical Examiners, classified among the "Eyesight Swindlers." The United States post-office inspectors are rounding them up throughout the United States.

Another eyesight swindler, named Louis Levy, was reported arrested in Los Angeles December 2, 1936, by post-office inspectors.

"Two women, arrested in a raid on a house at 947 Neptune Street, Wilmington, were booked at University police station last night on a suspicion of performing illegal operations. The women gave their names as Miss Elsie Spencer, twenty-six, and Mrs. Lillian Foster, twenty-seven, and said they were sisters. Acting on information furnished by a 16-year-old girl, Detective Lieutenant W. J. Sims and Policewoman Anne Lee investigated the Wilmington house and arrested Mrs. Patsy Dederich, twenty-one, of 1396 Louis Street, Long Beach, as a material witness. Mrs. Dederich was caught as she attempted to flee through a rear door, according to police. She said she had submitted to an operation yesterday. She was taken to General Hospital for medical examination." (Los Angeles *Illustrated Daily News*, January 7, 1937.)

"At least one illegal operation occurs to every three confinements, it was revealed in an article by Gretta Palmer, appearing in the current issue of *Pictorial Review*. 'Not to Be Born' is the title of this daring, yet delicately written, article. In a foreword the editors of *Pictorial Review* announce that before deciding to publish Mrs. Palmer's article they had several hundred women

selected at random read it and offer suggestions. While some of these women objected to certain portions of the article, which were deleted before publication, there was no serious objection to the publication of the article, which will cause untold thousands to give thought to the illegal operations performed in this country. 'Every day twenty-two women in the United States die trying to avert bearing children,' says Mrs. Palmer. 'Writers and physicians have been telling women's clubs for years that our country has a shockingly high maternal mortality rate, compared with the rest of the world. . . . That between six and seven American women out of every thousand die in childbirth. They have not often told us that fully one-fourth of these fatalities are not genuine childbirth cases at all. They are deaths resulting from blundering efforts to destroy the child-to-be. The vast majority of them occur in the first three months of pregnancy.' Mrs. Palmer gives some astounding statistics concerning illegal operations and their results. These include: Approximately 700,000 abortions are performed in this country annually. There is one illegal operation to every five pregnancies. More than 8,000 women died from abortions every year in the United States. In 1890 there was one abortion to every seven confinements. Today the ratio is one to three. Sterility is the commonest after-effect of a 'successful' operation of this kind. Nine per cent of the women who have one abortion become sterile; 18 per cent of those who have two or more." (San Francisco *Call-Bulletin*, January 14, 1937.)

"Federal Judge Cosgrove next Monday morning, in Los Angeles, will pronounce judgment in the Government's case against Richard Diener of Oxnard, charged with using the mails to sell a patent medicine, which he represented falsely. Diener changed his plea of guilty after a jury had been selected to try the case and, through the advice of his attorney, Charles Blackstock, made application for probation. Before judgment is pronounced, Federal probation officers will submit to the court the



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result of their investigation into Diener's record. As head of the Curarina Agency of Oxnard, Diener was charged with selling the medicine through an intensive mail-order campaign, representing that it would cure cancer, heart trouble, blood disease, rheumatism, and other ailments. Government chemists charge that the medicinal product contained none of the properties claimed for it." (*Ventura County Star*, December 3, 1936.) Diener and his product, Curarina, were mentioned in the *Journal of the American Medical Association*, February 29, 1936, page 724.

"Police are hunting a man who gave his name as 'Dr. Henry McCall,' Medico-Dental Building, when he passed a spurious check on Kern's Bakery for \$12. The check, signed with the name of Mrs. Irma Wilbur and drawn on the Hunter Square branch of the Bank of America, was passed December 12. The complaint was sworn to by Kern Monday." (*Stockton Record*, December 30, 1936.)

According to a news item printed in the *Los Angeles Illustrated Daily News*, December 31, 1936, Dr. Garnet King, 2025 South Grand Avenue, Los Angeles, assertedly has perfected an improvement in ether anesthesia. He is quoted as saying: "All I did was to devise a simple method of preheating ether so that it was drawn into the patient's lungs as a pure gas mixed with air or oxygen. Explosions are now impossible. There can be no ether pneumonia following the operation, and there is no resultant nausea. . . . When it was finally ready it was just a simple little apparatus, an ether container and a hot water thermos jacket. . . ." The records of the Board of Medical Examiners do not show anyone by the name of Garnet King licensed under the Medical Act.

"Because of insufficient evidence, Dr. Jack Smitherman was absolved of all blame Wednesday for the death of

21-year-old Virginia Sandefur, who died following an illegal operation December 1." (*Los Angeles New Age Dispatch*, December 18, 1936.)

"For the second time the State Supreme Court today denied the appeal of E. B. Hartman for a Writ of Habeas Corpus to release him from San Bernardino County jail, where he is serving a term for violating the State Medical Practice Act. He contended that he did not specify 'Doctor of Medicine' when he used the title doctor." (*Fresno Bee-Republican*, December 29, 1936.)

"Placed under \$5,000 bail by Justice Ernest Beam, Dr. Melvin R. Miranda, charged with two counts of negligent homicide and two counts of manslaughter in connection with the traffic death of Mr. and Mrs. M. J. Wilsey of Long Beach last Sunday, was in the county jail today, awaiting trial on December 15. He was arraigned yesterday in the Signal Hill Township Justice Court, and represented by Attorney Edward G. Haumesch. The bail was not met and Doctor Miranda was returned to the county jail by Investigator Tom Daniels of the Norwalk sheriff's office. Inquest into the death of the two Long Beach residents, who met their death while going to the aid of other motorists, was set for December 10." (*Long Beach Press-Telegram*, December 9, 1936.)

"Weird circumstances in the mysterious death of Ella Mae Clemmons, wealthy eccentric, who was known as the 'Christ Angel of Chinatown,' may never be explained. . . . Criminal procedure in the strange case was dropped yesterday when Hjalmar Groneman, the chiropractor who married Miss Clemmons on her virtual deathbed and laid claim to her entire estate, appeared for trial on a manslaughter indictment. Superior Judge Sylvain J. Lazarus

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

dismissed the case after hearing that the combined efforts of police and Department of Justice have failed to locate Charlotte Engberg, comely blond nurse and chief State witness. Judge Lazarus stated, however, that the dismissal does not give Groneman immunity. If Miss Engberg ever is found and the State decides to proceed anew, it can ask the Grand Jury for another indictment on the same charges. . . . Miss Engberg attended Miss Clemmons as nurse and was the State's sole witness on Groneman's alleged culpable negligence. . . . Shortly before the manslaughter indictment was returned, Groneman and the nurse announced they were engaged and would wed soon. Then Miss Engberg disappeared. It was brought out that she had lived with Groneman both before and after his marriage. . . ." (San Francisco Examiner, December 18, 1936.)

"For performing an illegal operation last August 27, which resulted in the death of Mrs. Hazel Scott, forty-three, Mrs. Regina Holscher, fifty-eight, yesterday was sentenced by Superior Judge Charles W. Fricke to a year in the county jail as condition to being granted five years' probation. In the probation report Mrs. Holscher admitted having performed at least one illegal operation each month for the last year." (Los Angeles Illustrated Daily News, December 19, 1936.)

Under date of December 21, United States Post Office Inspector C. W. B. Long reported that Matthew O. Wilkinson, Harold N. Baxley, and Curtis Yager were recently convicted of eyesight swindles. Matthew Wilkinson is featured in the 1930 report of the Board of Medical Examiners in the article entitled "Eyesight Swindlers."

In the nature of things youth cannot be aware of its latent powers.

"Seven Steps to the Undertaker" by Frank L. Rector, M. D.*—For the past six years the writer has devoted full time to the cancer educational field in a territory comprising the states of Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, and Wisconsin. During this time the cancer problem has been discussed with hundreds of physicians and with thousands of laymen. Frequent attendance at the cancer exhibit of the American Society for the Control of Cancer at the Century of Progress, which was visited by 1,500,000 persons during its two years of operation, offered a unique opportunity for finding out what a vast cross section of the population was thinking about cancer. This experience has been augmented by frequent addresses to public groups with opportunity for questions from the floor.

As a result of these experiences, questions have been repeatedly asked by the laity and statements made by physicians that indicate fairly well the trend of thought of these two groups regarding cancer. It is believed that a frank discussion of the attitude toward the cancer problem as shown by certain physicians, which attitude is so at variance with known facts about the disease and so inimical to the patient's welfare, should do much to bring about a changed situation that will benefit the entire profession.

In justice to the large majority of physicians who have a right conception of the cancer problem, it should be said that the attitudes under discussion are usually those of physicians who have been in practice many years and whose experience with cancer in their early years of practice was discouraging. These older physicians have shown by their fallacious ideas that they have not kept pace with developments in the clinical and educational cancer field. Unfortunately, some of these physicians hold positions of influence and responsibility in medical organizations that cause the younger men of the profession to look to them

(Continued on Page 26)

* Field representative, American Society for the Control of Cancer.

From the Bulletin of the American Society for the Control of Cancer.



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(Continued from Page 24)

for leadership in scientific as well as organization problems. These erroneous and antiquated ideas concerning the relation of the public to the cancer problem will be discussed under seven headings, or steps, the following of which to their logical conclusion has suggested the title for this paper.

Step 1. "Efforts to enlighten the public about cancer only stimulate cancerphobia and increase morbid fears about the disease." As the basis of fear is ignorance, and as ignorance has its roots in mystery, it would seem logical to assume that fear would be banished when mystery is dispelled. The only way to overcome mystery and ignorance is by education. . . .

Step 2. "Cancer education drives the public to quacks." For hundreds of years there has been little change in the willingness of human beings to accept at face value the specious arguments of those with questionable goods to sell, whether these goods are of material value or service, as witness the prosperity of fake stock and bond salesmen. Just so the cancer quack flourishes because he offers a positive cure by treatment other than surgery which is so abhorrent to many people.

The physician who fails to tell his patient frankly what ethical medicine has done and can do for cancer is playing directly into the hands of these charlatans. . . .

Is not the implication for the profession clear in such a situation, and the neglect to satisfy the patient of ability to treat cancer as well as other diseases but another step in that patient's progress toward the undertaker?

Step 3. "The profession has no cure or even hope to offer the cancer patient." This attitude is utterly defenseless on the part of any physician engaged in the ethical practice of medicine. It places the physician expressing such views in the era represented by leeching, blood letting, wormy chestnuts, and rabbits' feet as therapeutic and preventive methods of medical practice.

It is a sad truth that more than half the cancer patients still seek medical aid for the first time after they are so involved that a cure cannot be expected. They do this because of ignorance and the fallacies and fears that beset them at these times. . . .

Instead of cancer being an incurable disease for which there is no hope for the patient, it is known to be curable when treated in early stages, and it can be palliated to the comfort of the patient in later stages. The physician who assumes a hopeless attitude toward his cancer patient is forcing him one step nearer the undertaker.

Step 4. "Treatment often increases the patient's suffering." Proper surgical therapy cannot be accused of increasing the cancer patient's suffering. Radiation sickness was a distressing condition with many patients until methods were perfected which eliminated it, except in those individuals who had an idiosyncrasy toward the rays of x-ray and radium. It is believed that this group of patients is no larger than that found with idiosyncrasies against many drugs.

Today no physician with experience in cancer therapy hesitates to give indicated treatment for fear of increasing the physical suffering of the patient. . . .

Step 5. "By telling the patient the truth, his condition is often aggravated." This fallacious argument has been answered in part earlier in this paper. If the medical profession is not willing to tell the public the facts about cancer as they do about other diseases, such as tuberculosis and diphtheria, they can expect many people will worry over the problem. On the other hand, those physicians and hospitals making a general practice of telling patients frankly when they have the disease, report only the fullest cooperation of the patient in his treatment. Barring the occasional neurotic who has a new phobia at frequent intervals, the average intelligent patient is inclined to take his illness sensibly. . . .

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Step 6. "The patient will not coöperate in treatment." It is doubtful if more cancer patients fail to coöperate in treatment than do patients with other diseases, such as tuberculosis, venereal disease, heart disease, and others where the treatment is of necessity prolonged. The average patient is anxious to get well and becomes restless, especially during convalescence.

When it is explained convincingly to the cancer patient that his treatment, particularly if it is radiotherapeutic in character, must be prolonged far beyond apparent recovery, and in any event that he must coöperate with the physician for his own safety, he will be found as responsive as the average patient. . . .

Step 7. "A watchful-waiting attitude on the part of the physician is often the best method to pursue." This argument advanced by some physicians is the most fallacious and damaging to the patient's welfare of all those discussed. It would be just as logical in the face of an epidemic of smallpox or diphtheria for a physician to wait for positive symptoms of the disease before vaccinating or immunizing his patients. Some physicians may be constitutionally opposed to discussing the patient's condition in his presence, but this type will pass as the public becomes better informed on health and medical matters, and patronizes only those physicians who will take them into their confidence.

The physician who fails immediately to utilize accepted methods for obtaining a diagnosis of his patient's suspected cancer, waiting for more positive signs of the disease, is by each day's delay lessening that patient's chance of survival. The patient may be excused for his delay in seeking medical aid because of ignorance of the significance of the symptoms; but for the physician to temporize with the case after being consulted is inexcusable from every point of view. . . .

An effort has been made to criticize constructively some of the retarding factors in the cancer education program. These factors are similar to those encountered in other health education movements. It will be remembered that many physicians in the beginning opposed the tuberculosis program as tending to alarm the laity unduly, and urged

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that methods for its prevention and control be *not* discussed in public. In many ways the cancer problem today parallels the tuberculosis program of thirty years ago.

It is really amazing the views held by some physicians about cancer. These vary from a strong leaning toward the fallacy that the mind has an influence over the growth or retardation of tumor tissue to the belief that the disease is contagious if not directly inherited. When pressed for proof of these views, it is always lacking.

With the new information that is accumulating daily, and with the intelligent lay interest becoming manifest in a better control of the cancer problem, the outlook is bright for a marked reduction in deaths from this disease. The medical profession has the opportunity to write another brilliant chapter in the conquest over disease by accepting whole-heartedly the responsibility for a service which it alone can render.

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★ *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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Menaces to Eyesight.—Indiscriminate use of weight reducers, hair dyes, and depilatories is causing serious injury to eyesight in the United States, according to a warning by Dr. Walter I. Lillie, in the current issue of *The Sight-Saving Review*, quarterly journal of the National Society for Prevention of Blindness.

Case stories of eye tragedies among his patients are cited by Doctor Lillie, and he gives the trade names of the "beauty products" which the victims used. Doctor Lillie is a practicing ophthalmologist in Philadelphia, and a member of the Department of Ophthalmology of the Temple University School of Medicine there. Writing on "Cosmetics Detrimental to Vision," he says:

"Individuals who use cosmetics are unwittingly subjecting themselves to visual dangers. We are all potential victims, because the present antiquated Food and Drug Act, passed in 1906, only requires the manufacturers of food and drugs to properly label their products, but does not penalize the acts of adulteration and misbranding. False and fraudulent therapeutic claims must be proved before the product can be removed from the market.

"These two little words, 'and fraudulent,' compel the Government to prove that the manufacturer knows the customer is being swindled. This has prevented any adequate control over quack or dangerous remedies. Extraneous advertising of these products through the newspapers, magazines, and radio is without federal control, and because of this we are constantly reminded of the wonderful benefits and cures that will be derived from their use.

"Today the billion-dollar-a-year cosmetic industry is not subject to any federal regulations unless the labels bear medicinal claims, which, of course, never occurs. There is no legal way to protect the public against dangerous cosmetics. Toilet preparations which are known to be harmful by the medical profession cannot be taken off the market regardless of any disfigurement or injury they may inflict. Although poisonous cosmetics that ravage their users by paralyzing, blinding or disfiguring them are the exception rather than the rule, the medical pro-

APPROVED CLINICAL PATHOLOGISTS

American Medical Association Essentials for An Approved Clinical Pathologist

An approved clinical pathologist should be a licensed graduate of medicine. He shall have specialized in clinical pathology, bacteriology, pathology, chemistry, and other allied subjects for at least three years, and he should be reasonably familiar with the manifestations of disease in the body. The director of a clinical laboratory shall be on full time or have definite hours of attendance, devoting the major part of his time to this specialty. A clinical laboratory is an institution organized for the practical application of the fundamental sciences by the use of specialized apparatus, equipment and methods, for the purpose of ascertaining the presence, nature, source, and progress of disease in the human body.

The following Clinical Pathologists directing private laboratories in California are approved by the Council on Medical Education and Hospitals of the American Medical Association:

**Clinical Laboratory of Drs. W. V. Brem, A. H. Zeiler, Roy W. Hammack
and G. D. Maner, 657 So. Westlake Avenue, Los Angeles, California.**

Zera E. Bolin, M.D., 490 Post Street, San Francisco, California. . . .

These laboratories use standard methods and are fully equipped to make all clinical examinations of recognized value in: Tissue Pathology, Bacteriology, Hematology, Serology, Bio-Chemistry, Kolmer Wassermanns, Kahn test, Medico-legal, Basal metabolism, Blood chemistry, Hormone Test for Pregnancy, Parasitology, Cardiology, Autogenous vaccines, etc.

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fession should be alert to the possibilities and probabilities of visual and bodily damage which may result from their use.

"The untoward visual effects may be temporary or permanent, depending upon the nature of the ingredient or the amount used, and the tolerance of the individual. The eyes are usually affected in one of two ways, either through direct contact with the preparation or indirectly through the absorption of the poisonous ingredient in the body. Three groups of cosmetics have the potentiality of producing severe ocular damage, namely, (1) weight-reducing preparations, (2) hair dyes, and (3) depilatory ointments.

"The present Administration has asked for a new Food and Drug Act which will give consumers better protection than the present antiquated pure food law affords. The officials of the Department of Agriculture have drafted the Copeland Bill (erroneously called the Tugwell Bill), which is proposed in the interest of the public and the honest manufacturer. This Act is to afford federal control of the manufacturing, labeling, selling, advertising, and shipping of prepared foods, drugs, and cosmetics.

"This bill is actively supported by the American Medical Association, American Federation of Labor, the National Congress of Parents and Teachers, and eleven other national women's organizations. A powerful opposition lobby has been organized and is sponsored by the Proprietary Association of America and numerous allied groups. Their apparent aim is to keep the present inadequate federal regulations unchanged, and so far their efforts have delayed constructive legislative action.

"A new law must be passed to insure the public of a deserved protection. We as individuals and as members of medical organizations should put forth every effort to obtain adequate legislation against the promiscuous sale and use of poisonous foods, drugs, and cosmetics."

Medicine absorbs the physician's whole being because it is concerned with the entire human organism.—Goethe.

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Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$——, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$——, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the —— Gift, the following described real property situate in the County of ——, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.



A VETERAN'S BIRTHDAY...

Five years ago Abbott and a cooperating laboratory offered Haliver Oil with Viosterol to the physician. It was born of original research at a time when much uncertainty surrounded the potency of many of the vitamin products on the market. Thereafter the physician could prescribe Abbott's Haliver Oil with complete assurance that his patients would get all those vitamins he intended them to have. And he did, after Abbott's ethical promotion presented him with the facts.

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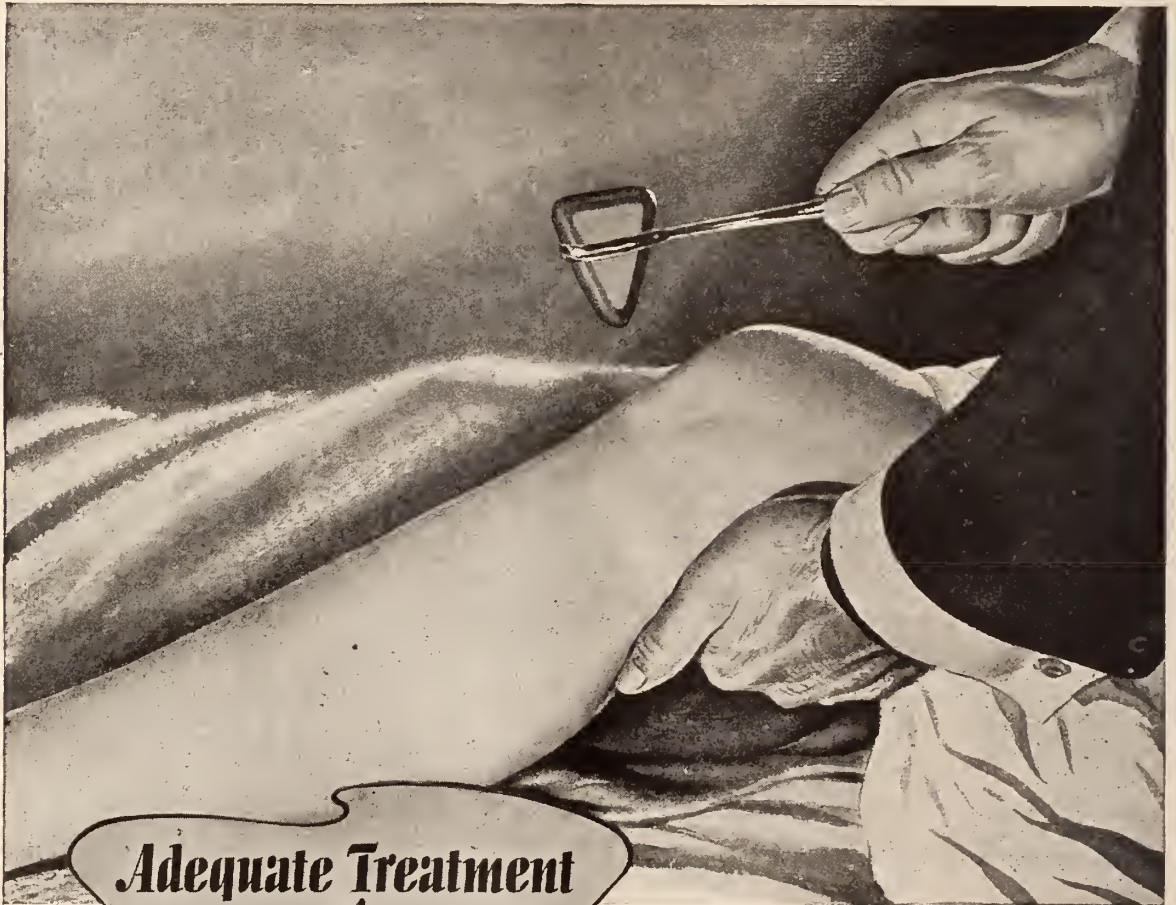
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EDITOR GEORGE H. KRESS

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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles; Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

THE MILL OF THE FIFTY-SECOND CALIFORNIA LEGISLATURE

Tentative Report on Bills Introduced.—At this writing it is not possible to give much information concerning proposed laws with public health implications which, up to the present, have been submitted to the Fifty-second California Legislature, now in session; because most of the important measures are still in their formative drafts.

At a meeting of the Council held in San Francisco on January 16, Dr. Junius B. Harris of Sacramento, chairman of the California Medical Association Committee on Public Policy and Legislation, gave a bird's-eye view of the legislative situation, and the picture he painted was in line with former experiences. The Council minutes record the action taken by that body in its all-day session.*

* * *

Three Important Measures: Medical Practice Act Codification; Medical Service Associations; Hospitalization Plan.—Three measures, in which the members of the California Medical Association have a special interest at this time, are:

1. The Medical Practice Act, as revised by the Code Commission. Through conference between representatives of the State Board of Medical Examiners, the California Medical Association and of the State Code Commission, it is hoped that the laws governing medical practice, in the new code, have been clarified without in any way detracting from their power.

2. The proposed law governing Medical Service Associations, as prepared by the Council's Special Committee and legal counsel, was carefully considered by the Council, section by section, and authority given to submit it to the Legislature. (See Item 13 in Council minutes.)

One or more measures of somewhat similar purpose have already been introduced on behalf of interests whose identity is not known. More of these in later issues.

3. A proposed Hospital Service law, sponsored by the Associated Hospitals of Southern California, was read, discussed and approved by the Council, and the chairman of the Los Angeles

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column, which follows.

* Council minutes are printed in this issue, on page 120.

County Medical Association Committee, Dr. William H. Kiger, was given authority to have the bill presented to the Legislature. This bill will take the place of Assembly Bill 246, which was enacted by the previous legislature, and contains provisions which the State Insurance Commissioner feels will add to its value and safeguards.

* * *

Other Proposed Laws.—Six skeleton bills to amend Medical Practice Act:

Among other items of proposed legislation, it may be of interest to note that one assemblyman has introduced a half-dozen "skeleton bills" to amend the Medical Practice Act; the entire texts of which measures, at the time of this writing, contain nothing more than the meager language:

An act to amend Chapter 5 of the Business and Professions Code, relating to the practice of medicine and surgery, and other modes of treating the sick or afflicted.

The people of the State of California do enact as follows:
1 Section 1.

What this assemblyman proposes later, on behalf of himself and friends, to insert in his array of measures, remains to be seen!

* * *

Clinical Histories of Patients No Longer Confidential(?):

Assembly Bill No. 385 is not long, and will probably shock most physicians and hospitals, who are prone to look upon history records as confidential communications. It is a joint presentation of seven assemblymen; and because of its comparative brevity, it is here printed in full:

ASSEMBLY BILL No. 385

Introduced by Messrs. Clark, Peek, Hornblower, Lore, Pelletier, Hawkins, and Rosenthal
January 13, 1937

Referred to Committee on Hospitals and Asylums

An act to add section 10½ to the Workmen's Compensation, Insurance and Safety Act of 1917, relating to records of persons receiving compensation thereunder.

The people of the State of California do enact as follows:

SECTION 1. A new section is hereby added to the Workmen's Compensation, Insurance and Safety Act of 1917, to be numbered Section 10½ and to read as follows:

Sec. 10½. All records of any hospital, clinic, sanitarium, physician, surgeon, or other person or institution in respect to services rendered to any person under the provisions of Section 6 of this Act, including but not restricted to x-rays and histories of injuries and diagnoses, shall be exhibited to the patient and to any person authorized in writing by him to examine the same. Any such person or patient shall be permitted to make copies of such records, including, but not restricted to, photostatic copies. Violation of any of the provision of this section shall constitute a misdemeanor.

* * *

Assembly Bill No. 384, a bill couched almost in the same language, is entitled:

An act to add Section 4055.5 to the Labor Code, relating to records of persons receiving compensation thereunder.

The people of the State of California do enact as follows:

* * *

False Advertising by Radio:

Then there is Assembly Bill No. 288 which, if enacted, may apply to some of the atrocious mis-

representations so frequently heard in radio broadcasts concerning curative agents. It is entitled:

An act to add Section 654d to the Penal Code, relating to false advertising by radio, and providing penalties for the violation thereof.

The people of the State of California do enact as follows:

* * *

Milk Production and Distribution:

Two bills having to do with milk (Heisinger Assembly Bill 50 and Thorp Assembly Bill 77) are commented upon by Dr. J. C. Geiger in the Letters department of this issue. (See page 132.)

* * *

Pay Patients in County Hospitals:

Assembly Bill No. 51, introduced by Mr. Heisinger, has been referred to the Committee on County Government, its short title being "County Hospitals Admission Amendment." It would permit a county board of supervisors to "provide for the admission of pay patients to the county hospital."

* * *

Narcotic and Other Measures:

Among other bills are several which deal with narcotic regulations, the licensing of clinical laboratory technologists and technicians, and various public health matters.

These and other proposed laws will receive comment in later issues of the OFFICIAL JOURNAL.

A NATIONAL DEPARTMENT OF PUBLIC HEALTH

The Effort Twenty-five Years Ago.—About twenty-five years ago considerable effort was made by the medical profession throughout the country to secure the enactment of legislation that would provide for an additional department—that of Public Health—to be represented in the cabinet of the President of the United States. Those endeavors, however, made very little impression upon Congress or the lay public. As a matter of fact, the attempt brought such a disheartening response that some who had enlisted in the cause came to the conclusion that it was a proposition almost permanently hopeless.

In the same issue of the OFFICIAL JOURNAL,* in which these comments appear, is also printed a paragraph written twenty-five years ago by the late Philip Mills Jones, as follows:

Owen Bill.—A number of requests for a copy of the last Owen bill to create a Department of Public Health have been received, and as the matter is of the greatest importance to public health, the *Journal* elsewhere in this issue, prints the bill in full. It will probably be some time before the Congress will enact any law of this nature, and it is quite possible that when such a law is finally passed it will differ somewhat from the present proposed measure . . . California State Journal of Medicine, Vol. X, No. 2, February, 1912.

* * *

Different Attitude With Changing Times.—However, times have changed, and with the social unrest of the past few years, a shift of view has

* See Twenty-five Years Ago department, on page 144.

taken place, and given rise to a movement to bring into existence not one, but two or more new administrative departments in the national government, each to include bureaus doing work in associated fields, but which, at the present time, have places in departments far apart in their basic organization and activities.

* * *

Recent Action of the American Medical Association Trustees.—In January, at a special meeting of the Board of Trustees of the American Medical Association, that body adopted the following resolutions worthy of the thought of every licensed physician and surgeon:

Recognizing that committees of the Senate and of the House of Representatives of the United States Government, and a special committee appointed by the President are at this time concerning themselves with the reorganization of government activities with a view to greater efficiency and economy, and recognizing also that the President, in his opening address to Congress, indicated that he would shortly present to the Congress recommendations for such reorganization of governmental activities in the executive branches, and recognizing, moreover, the great desirability that all activities of the Federal Government having to do with the promotion of health and the prevention of disease might with advantage be consolidated in one department and under one head, the Board of Trustees of the American Medical Association would recommend that such health activities as now exist be so consolidated in a single department which would not, however, be subservient to any charitable, conservatory or other governmental interest. It has been repeatedly said that public health work is the first problem of the State. It is the opinion of the Board of Trustees that health activities of the Government, except those concerned with the military establishments, should not be subservient to any other departmental interests. This reorganization and consolidation of medical departments need not, under present circumstances, involve any expansion or extension of governmental health activities, but should serve actually to consolidate and thus to eliminate such duplications as exist. It is also the view of the Board of Trustees that the supervision and direction of such medical or health department should be in the hands of a competently trained physician, experienced in executive administration.

In which statement we would call particular attention to the words:

"... the Board of Trustees of the American Medical Association would recommend that such health activities as now exist be so consolidated in a single department which would not, however, be subservient to any charitable, conservatory, or other governmental interest."

* * *

County Medical Society Resolutions.—In resolutions, which later may be considered by component county societies of the California Medical Association, the above requisites should always be emphasized. We must all acknowledge that the experiences of the last several years, in California and other states of the Union, have amply and repeatedly demonstrated to physicians the real and serious danger to high standards of medical practice when lay theorists—whether professors of economics, statisticians, directors of foundations, advanced social-service workers, or paid or free-lance propagandists—are given positions of responsibility in which they have direct or indirect supervision over the professional work of physicians and surgeons.

A National Department of Public Health With Its Secretary in the President's Cabinet Is Needed.—The United States of America needs very much a national Department of Public Health, having as its head "a competently trained physician, experienced in executive administration"; but it would be a deplorable error to link up the United States Public Health Service, and other affiliated agencies in preventive and curative medicine, with social welfare and similar groups; which, because of more intimate contacts with political influences, would be almost certain to warp and handicap real progress in work for the national public health.

* * *

California Medical Association Council Is in Accord With the American Medical Association Policy.—In view of the action taken by the Board of Trustees of the American Medical Association* (with which the Council of the California Medical Association is in full sympathy), it is quite in order for every component county society to pass proper resolutions, to be sent to Senators Hiram Johnson and William McAdoo, and to the congressmen of their respective districts, with an explanatory letter of transmittal asking coöperation and support for a national Department of Public Health organized along lines as above indicated. Members or committees in component county societies, therefore, who are interested should confer with one another and draw up such resolutions to be presented at early meetings. If preliminary drafts of resolutions are sent to the Association Secretary, he will be glad to advise and suggest. In any case, copies of resolutions, with the names of senators and congressmen to whom they have been sent, should be forwarded to the Central Office of the Association, at San Francisco.

"SECURITY FOR THE DOCTOR MEANS INSECURITY FOR THE PATIENT"

President of Medical Society of State of New York Speaks.—A newspaper item which recently appeared in the *Syracuse Herald*, containing excerpts from an address by Dr. Floyd B. Winslow, president of the Medical Society of the State of New York, has been called to our attention. Doctor Winslow's incisive remarks are worthy of perusal and are submitted for the consideration of the readers of *CALIFORNIA AND WESTERN MEDICINE*. Quotations follow:

Dr. Floyd B. Winslow of Rochester, President of the Medical Society of the State of New York, is assailing attempts to "foist" compulsory sickness insurance in this country.

In a speech to 150 physicians gathered in annual convention from seven upstate counties, Doctor Winslow said:

"Security for the doctor means insecurity for the patient."

He characterized as socialized medicine certain plans being promoted for compulsory sickness insurance.

"The advocates of these measures," he said, "lure the profession with the siren song of bureaucratic jobs, as—

* See *Journal of the American Medical Association*, January 16, 1937, page 208.

sured income—security—false security. We do not want to be secure. We want to remain insecure. We want to be required to continue to give our very best to every patient, or lose out in the gentlemanly competition which exists within our ranks.

"This is an incentive that operates to our insecurity, but to the security to the patient. We prefer the discipline of private practice which keeps us on our toes, to an assured income under bureaucratic control where our highest ambition is more likely to be to keep ourselves solid with the politicians who have taken over the job of running our profession."

UNITED STATES PUBLIC HEALTH SERVICE: ITS REPORT FOR THE YEAR 1936

How the "Marine Hospital Service" Has Grown.—From a Federal act, originally called the Marine Hospital Service law, signed on July 16, 1798, by John Adams, second president of the United States, and designed to give medical care to sick and injured seamen (for in those infant days of the Republic the mercantile vessels which made the Atlantic coast stations their home ports were a big factor in the prosperity of the Original Colonies), there has come into being during the succeeding 138 years a department known as the United States Public Health Service. It still carries on its original function, conducting twenty-five marine hospitals and 154 relief ports where merchant seamen may receive care as in Colonial days.

Two Federal narcotic farms, and Federal penal and correctional institutions, also receive its medical services, as do employees in the railway mail service. In addition, there has been developed, from the first beginnings, a Federal Public Health Service of great scope and efficiency; and in the report of Surgeon-General Thomas Parran, Jr., who, on April 6, 1936, succeeded his predecessor, Hugh S. Cumming, some of the major activities are outlined and may be worthy of further brief comment.

* * *

Decreasing Mortality Rates of Recent Years. New low death rates were recorded, in the preceding year, for typhoid fever, diphtheria and for infants under one year of age. The decrease in the death rate of tuberculosis and communicable diseases continues.

Chronic diseases, such as heart afflictions and cancer, baffle Federal and private physicians alike.

Three human cases of bubonic plague were reported from Western States, where rodent infestation is endemic. Smallpox was credited with 8,000 cases, many times more than should be in a supposedly enlightened age.

* * *

Research Activities.—The research activities of the United States Public Health Service included special studies of diseases such as "cancer, heart disease, malaria, Rocky Mountain spotted fever, poliomyelitis, leprosy, tularemia, plague, bacteriology, prophylaxis and therapeutics, pharmacology, zoölogy, and chemistry, and such additional subjects as industrial diseases, nutrition, child hygiene, dental investigations, milk sanitation, and stream pollution."

The Fight Against Syphilis and Gonorrhea. Mention is made of the greater attention which the Service is giving to venereal diseases, thanks largely to Surgeon-General Parran, who observes in his report:

When these diseases are brought out into the open, freed from the medieval concept of condign punishment for moral transgressions, and are dealt with as any other highly communicable diseases, the way is open to eradicate them just as we have stamped out other dangerous infections.

* * *

Medical Economic Surveys.—Another activity which should be of interest to readers, because of the Association funds, which, in conjunction with federal monies, have been expended on the California Medical Economic Survey, has to do with similar studies in other parts of the Union, concerning which it is stated:

The Public Health Service is engaged in the analysis of the enormous amount of data secured in the health inventory conducted in 1935 and 1936. This study included a survey of disabling illness, physical impairments, and facilities for medical care among 865,000 families in ninety cities and twenty-three rural counties—the most comprehensive survey of the kind ever undertaken in this country.

* * *

High Scientific Standard of United States Public Health Service Should Be Maintained.

From the above it is evident that the record of achievement of this medical branch of the Federal Government is one in which not only the Service personnel, but all physicians and citizens may take real pride. These beneficent results have been brought about in good part because, in the last 138 years, the United States Public Health Service has been permitted to go forward in the fulfillment of its functions, under the leadership of medical executives who have made the highest standards of scientific medicine an integral part of the Department's aims and work. During this period of more than a century, the Service has been able to remain free from political and propagandist influence, and the best interests of the States of the Union demand that it must so remain. Licensed physicians everywhere should give whole-hearted and active support to that end.

MORE CONCERNING AUTOMOBILE ACCIDENTS AND "VEHICIDES"

Previous Comment on the Subject.—In the October, 1936 issue, on page 307, of CALIFORNIA AND WESTERN MEDICINE, the subject of automobile accidents was commented upon, and it was stated that in the year 1935, among 1,285,000 accidents occurring in automobile traffic in the United States, a total of 37,000 citizens had been fatally injured!

Some reasons for this appalling record were briefly indicated, the suggestion being offered that here was a problem to which county medical societies and their auxiliaries should give serious attention.

* * *

Latest Figures for One Hundred Thirty-one Cities.—The Bureau of Census of the United States Department of Commerce in its report of

City and State	Total Number of Deaths				Deaths Due to Accidents in City			
	1936	1935	Increase or Decrease Over Previous Year	Per Cent Increase or Decrease	1936	1935	Increase or Decrease Over Previous Year	Per Cent Increase or Decrease
Total (131 cities)	9,599	9,777	-178	- 1.8	7,032	7,354	-322	- 4.4
Berkeley, California	22	29	- 7	- 24.1	11	17	- 6	- 35.3
Glendale, California	20	25	- 5	- 20.0	12	19	- 7	- 36.8
Long Beach, California	61	51	+ 10	+ 19.6	46	47	- 1	- 2.1
Los Angeles, California	537	552	- 15	- 2.7	433	451	- 18	- 4.0
Oakland, California	102	81	+ 21	+ 25.9	89	73	+ 16	+ 21.9
Pasadena, California	31	17	+ 14	+ 82.4	20	12	+ 8	+ 66.7
Sacramento, California	61	50	+ 11	+ 22.0	25	30	- 5	- 16.7
San Diego, California	59	76	- 17	- 22.4	41	59	- 18	- 30.5
San Francisco, California	92	60	+ 32	+ 53.3	90	60	+ 30	+ 50.0
San Jose, California	22	19	+ 3	+ 15.8	9	9	0	0
New York, New York	932	1,076	-144	- 13.4	932	1,070	-138	- 12.9
Chicago, Illinois	715	806	- 91	- 11.3	278	245	+ 33	+ 13.5
Philadelphia, Pennsylvania	282	245	+ 37	+ 15.1	704	772	- 68	- 8.8

January 13, 1937, gives "An Annual Summary for 1936, with Number of Deaths and Per Cent Change for 131 Cities," and states:

... A total of 9,599 automobile fatalities occurred during 1936 in 131 major cities, according to reports of the Bureau of the Census, Department of Commerce. The 1936 total was 178 fewer than the 9,777 reported for 1935. . . .

... Fatalities were reduced in New York and Chicago, the two largest cities in the country. . . .

... San Francisco reported 50.0 per cent more automobile fatalities in 1936 than in the previous year. In this city there were ninety deaths in 1936, and sixty in 1935. . . .

... The present report gives a summary of the figures for the years 1936 and 1935. . . .

... Tabulations show for each city the total deaths due to automobile accidents, and the deaths which result from automobile accidents within the city limits. The total deaths, therefore, include all those instances in which the automobile accident did not occur within the city proper, but in which the injured person was brought into the city, and died there. . . .

* * *

Ratings of Ten California Cities.—For the information of readers, the figures for the ten California cities listed in the report on 131 municipalities are given, the New York City, Chicago, and Philadelphia tabulations also being appended for contrast. (See table above.)

Is it necessary to add that mortality statistics such as the above provide food for serious thought?

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 119.

Health at New Orleans.—Telegraphic reports to the United States Department of Commerce from eighty-six cities with a total population of 37,000,000, for the week ended December 5, indicate that the highest mortality rate (21.3) appeared for New Orleans and that the rate for the group of cities as a whole was 12.2. The mortality rate for New Orleans for the corresponding period last year was 19.4 and for the group of cities, 12.2. The annual rate for eighty-six cities for the forty-nine weeks of 1936 was 12 as against a rate of 11.3 for the corresponding period of the previous year. Caution should be used in the interpretation of these weekly figures, as they fluctuate widely. The fact that some cities are hospital centers for large areas outside the city limits or that they have a large Negro population may tend to increase the death rate.

EDITORIAL COMMENT†

RECENT IMPROVEMENTS IN METHODS OF BIO-ASSAY*

Methods of performing biologic assay have recently been receiving considerable attention. The importance of the studies by Trevan¹ and Burn,² which make it possible to place this subject on a sound scientific and statistical basis, is being more generally appreciated.

The older method of injecting a series of animals with gradually increasing doses of the substance to be tested was usually not productive of a sharp end-point; frequently an animal receiving one of the larger doses would not react, while one receiving a smaller dose would give a positive test, thus leaving no definite level for the end-point. Anyone who has done much work in the biological laboratory knows that such a result is more common than to find a sharp demarcation in a series. Trevan and Burn have pointed out that animal variation must be considered in seeking biologic end-points, and that the only way to accomplish this is to inject a large number of animals with the same (submaximal) dose of the substance to be tested. The true end-point will then be represented by the percentage of reaction at that dose. If the percentage of reaction at several levels is determined, a toxicity curve can be constructed which will be characteristic of the reaction of that species to that drug. The percentage of possible error at the various levels can also be computed, using a formula which considers the number of animals used, the number of positive and negative reactions, and the size of the dose. The application of these concepts to older work based upon biologic assay has been productive of some surprising results.

† This department of CALIFORNIA and WESTERN MEDICINE presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

* From the Departments of Pharmacology and Medicine of the University of California Medical School.

1 Trevan, J. W.: The Error of Determination of Toxicity, Proc. Roy. Soc., 101:483-514 (July), 1927. Series B. London.

2 Burn, J. H.: Errors of Biological Assay, Physiol. Rev., 10:146-169, 1930.

A recent example is some work with the clinical modification of the Reid-Hunt acetonitrile test, which was said to indicate the presence of an increased amount of thyroid, or of thyreotropic hormone from the anterior pituitary, in the blood stream. The test was accomplished by noting the effect of injections of the blood serum to be tested upon the resistance of white mice to acetonitrile. Recent work³ applying the methods of bio-assay, as advocated by Trevan and Burn, to this test has shown it to be without any clinical value.

Another important fact requiring consideration is the number of preparations that are now on the market with potency expressed in various animal units. It is obvious that unless the proper methods of bio-assay are used, the potency of the marketed preparation will vary as much as the resistance of the animals used, and it would be of interest, therefore, to have more details concerning methods of biological assay from pharmaceutical houses offering assayed substances for sale.

384 Post Street.

ROBERTO F. ESCAMILLA,
San Francisco.

THE PHYSICIAN: SCIENTIST OR ARTIST?

Ignoring for the moment many secondary meanings, science may be defined as the classification and coordination of factual knowledge; art as the utilization or application of knowledge to accomplish desired results. In the former case, knowledge is static; in the latter it is dynamic.

If the foregoing definitions are correct, it is evident that the present-day tendency to regard medicine as strictly a science is ill advised. For reasons of policy, perhaps such a conception is well enough. But any scheme of classification that fails to consider the claims of art in the premises does violence to a fair appraisal of the question.

Most basic knowledge concerning the structure and functions of the human body obviously is derived from science. Equally obviously the practical application of that knowledge falls within the province of art.

All living things are manifestations of art in the sense that their interpretation may be approached only through the artistic faculties. It is not possible to apply to them the cold, formal, unchanging rules and methods of science. Science confines itself to the material, and refuses to concede that the difference between animate and inanimate matter is in any important respect significant. Conclusions adduced from the study of matter, even its minutest subdivisions, refer exclusively to physical states existing at certain definite moments of time, not to the constantly changing conditions which constitute the very essence of living processes. Science seeks only data that are fixed and stable relative to the material elements which form life's medium of expression.

To be sure, matter is the essential basis of life as mortals know it. But there is a profound and fundamental distinction between living and non-living matter, which in the very nature of things

science does not undertake to investigate and explain. Science relies on measurement, mathematical exactness. These depend upon sense perception. It follows that science cannot deal with the intangible factors involved in determining the normality or abnormality of the actions and reactions of living organisms, ordinarily called symptoms. Symptoms point the way, the only way, to diagnosis. And diagnosis is the heart of medical practice.

The complex problems relating to the interpretation of life and its functional activities lie wholly within the sphere of the artistic. This higher plane is the *fons et origo* of those familiar, but scientifically undemonstrable mental processes, analysis, abstract reasoning, logical deduction; and here alone the power to differentiate the abnormal from the normal, to select the one true from many possible conclusions, may operate. Imagination, intuition, inference, judgment—these are faculties belonging to the realm of art as truly as those employed in the appreciation of beauty or the enjoyment of great music.

A master painting is composed of material substance—canvas, pigments, oil. The revelations it makes to the cultured beholder are something other and more. The subtle qualities of perspective, harmony, charm, are in no sense identical with the physical components, however intimately dependent on them.

Until the mystery of life and the riddle of its meaning are solved, the vital phenomena of health and disease cannot be relegated to the domain of science where the yardstick reigns and demonstration by the physical senses is the court of last appeal. Even biology, the so-called "science of life," tacitly recognizes the dilemma and evades it by boldly assuming the fact of life, without claiming to comprehend, much less to explain it.

Medicine is both an art and a science. Any comparison as to relative importance would be invidious. Whether consciously or unconsciously, the physician in the pursuit of his daily duties must needs be an exponent of art no less than of science. Realization of this truth should be an inspiration as well as a constant incentive.

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A. B. COOKE,
Los Angeles.

The Automatic Control of Radium.—At the Westminster Hospital, where special attention has been given to radium therapy for some time, an important advance in technique has been made. The new installation incorporates a system of distant control for the better protection of operators and has allowed larger "bombs" to be used. Additional radium has been acquired to give effect to the conclusion earlier reached by the surgeons in charge of the radiotherapy department that deeper penetration can be obtained by removing the radium to a greater distance from the point of application. Four grams of radium, valued at about \$200,000, is used and is carried alternately by two bombs. By a system of automatic electrical control the radium in its container can be lifted from a leaden safe into one of the bombs and swung into position over the patient. The electrical switchboard is situated fourteen feet from the patient's couch. The two bombs and the radium container are made of a heavy ray-proof metallic compound recently invented. The installation, which has involved months of experimental construction and special tools, has cost about \$4,000 apart from the radium.

³ Escamilla, R. F.: Failure of the Reid-Hunt Acetonitrile Reaction as a Clinical Test for Hyperthyroidism. *Endocrinology*. In press.

ORIGINAL ARTICLES

PULMONARY EMBOLISM*

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AND

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DISCUSSION by Donald J. Frick, M.D., Los Angeles;
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M.D., San Francisco.

PULMONARY embolism is a frequent vascular accident which is too seldom detected before the patient reaches the autopsy table. A review of 236 chronologic necropsied cases occurring in the Los Angeles County General Hospital during the years 1931 to 1935, inclusive, has furnished us with the data upon which this discussion is based. Excluding the cases autopsied by the coroner, pulmonary emboli were found in 2.6 per cent of all necropsies. These autopsies were done by many individuals employing no special or uniform technique in searching for pulmonary emboli. There were many more cases of pulmonary infarcts and abscesses, and many of these were undoubtedly embolic; but no cases were included unless the embolus was described by the pathologists. Therefore, there were certainly numerous emboli which were not included in this incidence of 2.6 per cent. Many nonfatal cases were reviewed, but due to possible errors in diagnosis these were not analyzed statistically.

Although this condition is generally believed to be primarily a postoperative surgical complication, our series has amply demonstrated that a relatively small proportion of pulmonary emboli occur after surgical procedures, and that even in these cases there are usually accessory etiologic factors which are of primary importance. Autopsy analyses combined with clinical studies indicate that these accidents are frequently multiple, often unrecognized and are not necessarily fatal. In instances where death is not immediate, a clinical picture is usually presented which has certain fairly definite diagnostic characteristics.

CLINICAL MATERIAL FOR THIS STUDY

Our statistical information will be briefly reviewed in order to illustrate certain important conclusions. In this series of 236 cases there was an equal division between the sexes, there being 119 males and 117 females. Eighty-one per cent occurred after the age of forty. There were but four patients under twenty, and this is striking, considering the large number of children treated in this institution, where 17½ per cent of all admissions, excluding new-borns, were under sixteen years of age. The four cases under twenty were all associated with an active infectious process: two with cerebral sinus thrombosis following otitis

media, one with bacterial endocarditis, and one with rheumatic myocarditis complicated by jugular thrombosis. Where the embolus was unilateral the right pulmonary artery was involved more than twice as often as the left (sixty-six to twenty-nine), but in an equal number of cases (ninety-two) emboli were found on both sides. The main trunk was occluded in thirty-one instances, and in eighteen the location was not clearly defined. The arteries to the lower lobes were affected more frequently than those to the upper. It is of interest to note that multiple emboli were found in over one-half of the cases of the entire series (137). Forty-nine per cent of the total series developed pulmonary infarction, and this was most frequent in the right lower lobe. Icterus of the sclerae was present in twenty-two cases, and all but one of these had one or more pulmonary infarcts. In 84 per cent the pulmonary emboli were considered by the pathologist to be the primary or contributing cause of death.

INCIDENCE IN THE CHILDREN'S HOSPITAL
OF LOS ANGELES

We obtained further information on the rarity of this condition in patients under the age of thirteen from the Children's Hospital of Los Angeles. Between January, 1922, and June, 1936, there were 44,317 admissions. Between January, 1928, and June, 1936, there were 1,200 autopsies. In this total series there were only five cases in which pulmonary embolism was a consideration. There were two cases of sudden death a few hours after operation in which embolism was considered, but the recorded findings (without autopsy) did not support this diagnosis. There was one case of sudden death following a transfusion, which was given through a needle previously used for twenty hours for a continuous infusion of saline, in which thrombi were described only on microscopic sections of the lung. In a similar case, which also had a severe pneumonia, a "thrombus," one-fourth centimeter in diameter, was found in a pulmonary artery. In one case of infected circumcision, and staphylococcus septicemia, multiple abscesses in the lung were considered to be embolic in origin. There were, then, in this large group from the Children's Hospital, no cases that were clinically acceptable or in which a gross pulmonary embolus was identified at autopsy.

DIVISION OF PULMONARY EMBOLI INTO
THREE GROUPS

For purposes of comparison we have divided the cases of pulmonary emboli into three groups: those treated medically, 65 per cent; those following operation, 27 per cent; and those following trauma, 8 per cent. The most striking feature in the entire series—and this was, of course, most pronounced in the medical group—was the large number of cardiac cases. Thirty-five per cent had definite signs of decompensation, and another 17 per cent showed marked anatomical changes in the heart without decompensation. This represents 52 per cent of the entire series which suffered from severe cardiac disease. The incidence of pulmonary infarction was exceptionally high in

* Read before the General Medicine Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

† From the Department of Medicine, Medical School of the University of Southern California.

We wish to thank Dr. Newton G. Evans and the Pathological Department of the Los Angeles General Hospital for the use of the autopsy records.

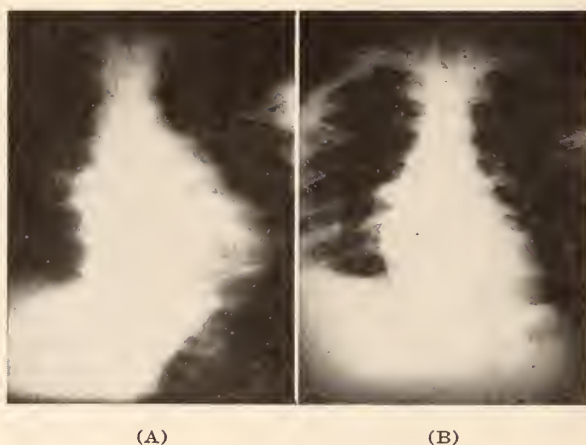


Fig. 1.—A. Three-foot anteroposterior view of chest three days after characteristic attack of pulmonary embolism. B. Three-foot anteroposterior view of chest twenty days after Film A. Note general cardiac enlargement and prominent pulmonary conus shadow in the first film. In the second film these have disappeared.

those suffering from congestive failure. These facts indicate that patients with cardiac disease, and in particular those with decompensation, are constantly candidates for pulmonary emboli. These are often small, frequently are not diagnosed, and are the reason for the multiple pulmonary infarctions so often seen at autopsy. In the surgical cases the embolus occurred most frequently between the fourth and the thirteenth day, with an average of eleven days. However, three were recorded as early as the first, and one as late as the thirty-first postoperative day. The time of appearance of the embolus, following trauma, averaged seventeen days.

SUPPURATION AS A CAUSATIVE FACTOR

In the total group of 236 the element of suppurations appeared to be an important causative factor. Frank collections of pus were discovered in fifty-two instances—twenty-nine in the surgical group of sixty-four, and twenty-three in the medical group of 153. Of these fifty-two, the location of the venous thrombosis was found in twenty-four instances, and in twelve of these the veins involved were directly in contact with the abscess. This suggests that the suppurative process was at times responsible for the formation of the localized venous thrombus. The incidence of abdominal suppuration was high—thirty-eight out of the fifty-two. Thirteen of these cases also had marked cardiac pathology or decompensation, indicating how combined factors may operate in a single case. It is interesting that the twenty-three cases of abscess in the medical group were candidates for surgery, but developed the pulmonary embolus before surgical intervention.

ACUTE PERIPHERAL THROMBOPHLEBITIS

We attempted to determine how often an acute peripheral thrombophlebitis might be considered the primary source of the embolus. There were only eleven such cases in the entire group. These figures are well in line with those reported by others, which indicate that fatal pulmonary embolism is not a common complication of an acute thrombophlebitis. The inflammatory process within

the vein sets up a reaction producing relatively firm adherence between the clot and the vessel wall, so that it is not readily released. The rarity of death from pulmonary embolism in the hundreds of thousands of injections for varicose veins is an additional proof of this contention. Here a deliberate effort is made to induce damage to the vessel wall and incite the formation of a clot, and the procedure is rarely followed by pulmonary embolism. In our group there had been no varicose veins injected, and there were only thirteen cases in which varicose veins were described.

MECHANICAL VENOUS COMPRESSION

In attempting to find a cause for the initial thrombus acting as a source for pulmonary emboli, we considered the question of mechanical venous compression, chiefly from tumor. We found definite evidence of such pressure in twelve patients, and felt that such a factor might have played a part in eleven more. There were several instances in which large pelvic tumors, generally of the uterus, could have produced pressure upon the veins within the pelvis. In the traumatic series of nineteen cases, casts had been applied to the lower extremities in six. In one case the cast was so tight as to cause considerable swelling of the foot and had to be removed. Death occurred suddenly two days later, and at postmortem examination thrombosis of the veins of the leg was described with multiple pulmonary emboli.

OTHER FACTORS

Obesity was mentioned thirty-five times, emaciation thirty, a decubitus ulcer was present in sixteen, and a malignant tumor was evident in thirty-four. Some form of prolonged debilitating illness preceded death in thirty-seven instances, twenty-eight of these being in the medical group. These were mostly far-advanced malignancy and also cerebral pathology, cord changes, psychoses, extra-pulmonary tuberculosis, severe pernicious anemia, and pellagra. They were all bedridden for long periods, more or less emaciated and dehydrated. It was believed that no definite conclusion could be drawn from these observations, although dehydration and impairment of circulation may have influenced thrombosis.

POSTOPERATIVE SERIES

It is of interest to note that of the sixty-four postoperative deaths there were only thirteen instances in which no etiologic factor other than the surgery could be discovered. The other cases gave evidence of suppuration, cardiac disease, acute phlebitis, sepsis, indication of prolonged venous compression or debilitating illness—factors which, in the nonoperative series, we found to be capable of producing thrombosis without surgical intervention. This observation emphasizes the importance of excluding various other sources of pulmonary emboli before attributing a postoperative attack solely to the surgical procedure. In only four cases, two of hysterectomy, one of hemorrhoidectomy, and one of herniotomy, were thrombosed veins found in the region of the operation.

SITES OF THE EMBOLI

The thrombus responsible for the embolus was found in 122 cases. Of this group the largest number, fifty-four, was found in the pelvic veins including the iliacs, the veins of the broad ligaments, and the periprostatic and perivesicular plexuses. Thirty-one cases of thrombosis of the various veins of the lower extremities were described. In twenty-three instances, emboli apparently arose from clots within the right auricle, and in three cases the probable source was a mural thrombus in the right ventricle. Many of the emboli of undetermined origin must have come from the legs, as these veins were rarely explored except where there was clinical evidence of thrombosis in the legs.

COMMENT

A review of this series of figures points to certain conclusions which we believe are of importance. The largest number of pulmonary emboli occur in medical rather than postoperative patients. In the vast majority of cases there is some predisposing factor which explains the appearance of venous thrombosis. Heart disease, with accompanying decompensation and congestive failure, is probably the most frequent of such factors. The most apparent mechanism of production of the venous thrombi in cardiac failure is the slowing of the venous current. This is well illustrated by the frequency of thrombi within the auricles in auricular fibrillation. A similar mechanism probably explains the thrombi produced by pressure upon the veins by tumors, casts, or bandages. Impaired venous circulation may also be produced by prolonged muscular inactivity and diminished respiration. Such conditions exist in any bedridden patient, and particularly in postoperative patients who have undergone any form of abdominal surgery. Venous slowing from lack of muscular action gives a reasonable explanation for the pronounced frequency of thrombosis in the veins of the lower extremity, where muscular activity is at a minimum, as compared with the rarity of thrombi in the arms which are frequently in motion and often elevated, even in a bedridden patient.

TRAUMATIC CASES

It seems significant that of the nineteen traumatic cases, fifteen were fractures of the lower extremities and three were fractures of the ribs. In the only other case there was a fractured skull, sinus thrombosis, and an infected embolus. There were five cases in the group with severe heart damage, and casts had been applied in six other instances. There were no cases of trauma to tissues without the fracture of a bone, which required a prolonged period of immobilization. The average length of time between the accident and the occurrence of the embolus was seventeen days. The fractured ribs undoubtedly resulted in depressed respiration. It would seem that venous stasis from cardiac disease, casts, depressed respiration, and muscular inactivity may also have been an important predisposing cause of venous thrombosis in the traumatic group.

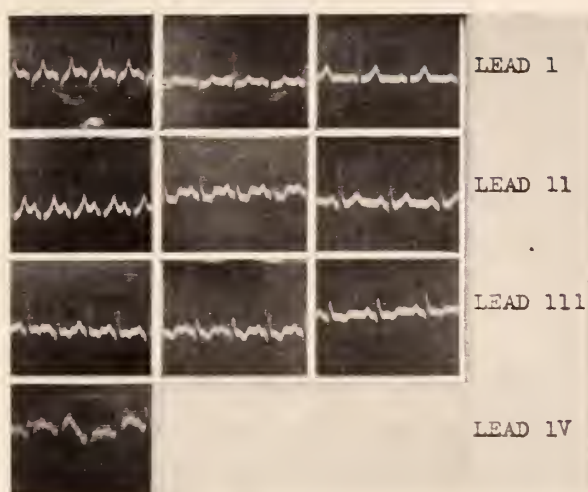


Fig. 2.—Serial electrocardiogram. The first taken four hours after a severe attack of pulmonary embolism and twenty-four hours after a mild attack. Lead IV taken with left arm lead over apex.

THROMBI

Unfortunately, the most dangerous type of venous thrombosis, from the standpoint of the likelihood of emboli, appears in those cases where the thrombosis is of the bland and noninfected type. Such patients give little or no indication of their condition, and the sudden appearance of a pulmonary embolus may be the first suggestion of an unrecognized thrombus. Where an actual inflammation of the intima of the veins develops, as in an acute thrombophlebitis, with accompanying swelling, redness and tenderness, there is not so great a hazard of the liberation of an embolus.

SIGNS AND SYMPTOMS OF EMBOLI

Although pulmonary emboli of large size are often fatal, there are probably many more instances where such is not the case. There is a great variation in the clinical picture produced, dependent upon the size of the artery occluded. When the embolus obstructs the main pulmonary artery, or one of its major branches, death may be instantaneous. If not, the patient suddenly presents the picture of extreme anxiety. He sits up in bed with rapid, shallow respiration and fights for breath. There is usually no severe pain, but a marked sense of substernal oppression and often a fear of impending death. The skin is pale, cold and wet with sweat. Cyanosis is usually present, which may be moderate or extreme. The pulse is rapid, small, and frequently disappears completely. Arterial blood pressure falls and venous pressure rises, so that distention of the cervical veins is usual and should be sought in every case. On auscultation the heart sounds are faint and rapid. An intensification of the pulmonary second sound is quite consistently present. This is a valuable sign and is often accompanied by a visible pulsation in the left second intercostal space close to the sternum. A to-and-fro friction rub may be heard in this area. If the patient survives the immediate attack, signs of right heart failure may gradually develop with increased venous distention, enlarged liver, and anasarca.

TABLE 1.—Review of 236 Autopsied Cases of Pulmonary Emboli *

Total hospital autopsies (1931-1935).....	7632		
Number with pulmonary emboli.....	207		
Incidence of pulmonary emboli.....	2.6%		
(Additional group from coroner's autopsies).....	29		
Embolism listed as cause of death.....	84%	Death occurring after 40.....	81%
Pulmonary infarcts.....	49%	Death occurring under 20.....	4 cases
Congestive heart failure.....	35%		
Severe cardiac damage.....	17%		
Total suffering from severe heart disease.....	52%		
		Group Classification	
			With Severe Cardiac Pathology
			Cardiac Decom- With Severe Cardiac
			pensation Pathology
		Medical.....	153
		Postoperative.....	64
		Post-traumatic.....	19
			77
			6
			0
			22
			13
			8
		Location of Embolus	
		Right.....	66
		Left.....	29
		Right and left.....	32
			31
			18
		Collection of Pus—52 Cases	
		Medical.....	23
		Surgical.....	29
			38 of these in abdomen.
		Primary Thrombus Described—122 Cases	
		Location—Pelvic veins.....	54
		Lower extremity.....	34
		Right heart.....	27
		Cerebral sinus.....	3
		Jugular.....	2
		Axillary.....	2

* Summary of statistical data more fully described in text.

The result depends to some extent upon the previous state of the cardiac reserve. There may be temporary improvement, followed by another immediately fatal embolus. Even the most severe attack, if not immediately fatal, may after a day or two show signs of improvement and be followed by complete recovery.

Emboli of smaller size will produce a much less dramatic and characteristic picture without the evidence of shock described above. There may be no more than a sudden increase in the respiratory rate, with slight substernal discomfort. The pulse suddenly quickens and there may be a slight cough. Later there may be depressed breath sounds, moderate dullness and a few râles in the lung. Hemoptysis is frequently present, but this may not appear for a day or two. There is often a sharp sticking pain in the chest on respiration; fever and a moderate leukocytosis usually appear. With these small emboli the signs of so-called cor pulmonale, described above, may be entirely absent. Such a picture occurring in a postoperative patient may raise the question of pneumonia or atelectasis. The suddenness of the onset and the lack of more definite physical signs would rather suggest an embolic accident. However, the presence of a large area of infarction may give all the signs of consolidation. Hemoptysis is not a constant feature, and when present is apt to appear some hours or days after the initial attack. It is more usual with cases of impaired circulation and congestive failure. The pain in the chest increased by deep breathing is produced by pleural involvement when the infarcted area reaches the surface of the lung. It is not always present and is usually absent at the onset. Embolic obstruction of smaller vessels producing few or no symptoms is undoubtedly common. There may be no more than slight and transient dyspnea, moderate pulse acceleration and slight substernal discomfort.

IMPORTANCE OF RECOGNITION OF EMBOLI

Although these minor embolic accidents may produce so few symptoms and signs, they should not be disregarded. Our review of these autopsies has demonstrated how often these emboli are multiple with evidence of previous clots in the pulmonary arteries which appeared at variable times before the fatal embolus. In cardiac patients with heart failure, in medical or surgical cases with suppuration, sepsis or prolonged confinement to bed, in postoperative patients (particularly those involving pelvis or abdominal surgery), one should keep in mind the likelihood of such an accident in connection with any development in the lung or heart. One should search with care for any evidence of venous thrombosis. Such a focus is usually not evident, but if found will substantiate the suspicion of pulmonary embolism. These patients should be watched with unusual care and one cannot overemphasize the necessity of absolute rest and avoidance of any slight exertion, such as straining at stool or urination, getting out of bed too soon, or moving too vigorously in bed. Fatal accidents often occur during such activity. When a pulmonary embolus is suspected, the period of convalescence and bed rest should be prolonged for four to five weeks.

ELECTROCARDIOGRAMS

The three electrocardiograms occurring in this autopsied series, together with a study of seven tracings in patients who have recovered from characteristic attacks of pulmonary embolism, have shown certain valuable diagnostic changes. S₁ is constantly present and usually of considerable amplitude. The S-T interval in both Leads I and II, arises well below the base-line and gradually ascends to the T wave. This may suggest on occasions a diphasic T, but we believe the change is due primarily to the S-T segment rather than to the T

wave itself. Lead IV (Wolferth derivation) shows constant abnormalities in the T wave, which is usually upright rather than downward, but may be diphasic or of abnormally low voltage. The prominent Q_3 mentioned by White was seen six times out of ten. The characteristics described above have been found to be present with a fair degree of regularity. They are of definite value in differentiating the acute cor pulmonale from an attack of coronary occlusion. However, we feel it wise to emphasize that such changes are not uniformly present—particularly in minor attacks—and that the form of the electrocardiogram in every instance must be influenced by preëxisting cardiac pathology.

These patients are usually too ill to be disturbed for roentgenograms. There were several pictures in this series which were of no diagnostic help. However, in one instance a pronounced exaggeration of the pulmonary artery shadow appeared in the cardiac silhouette. Two weeks later this had entirely disappeared. It is logical to expect such a change in the pulmonary artery if a major portion of the pulmonary arterial circuit has been obstructed. At times a triangular-shaped infarct may be seen in the x-ray film.

PULMONARY EMBOLISM AND CORONARY OCCLUSION

It may be well to emphasize the similarity and also distinguishing features between pulmonary embolism and coronary occlusion. In both instances the patient presents the picture of shock and collapse, with extreme dyspnea, orthopnea, and sweating. Coronary occlusion is apt to cause more severe pain with radiation to the arm, and pulmonary embolism is apt to cause more cyanosis. Accentuation of the pulmonary second sound and occasionally a pulsation or friction rub in this area are most important points, indicating a pulmonary embolus rather than a coronary accident. Pulsation of the cervical veins, pain on respiration, jaundice, and hemoptysis, are more frequent following pulmonary embolism. A previous history of angina pectoris would suggest coronary occlusion, while congestive failure, prolonged bed rest, or signs of venous thrombosis would favor embolism. Electrocardiograph changes may occur in both conditions, but usually present distinguishing features.

Other conditions which may prove confusing are spontaneous pneumothorax, dissecting aneurysm, pneumonia, pulmonary atelectasis and acute upper abdominal accidents, as perforating peptic ulcer. These should be relatively easy to differentiate, with an adequate history and careful physical examination.

PREVENTIVE THERAPY

Prophylaxis is more important than treatment. Keeping in mind the various predisposing factors to venous thrombosis, one should make every attempt to prevent such conditions. Patients should not undergo elective operations with any degree of cardiac decompensation. Those who must face emergency surgery while showing circulatory failure should have careful postoperative care under

competent medical supervision. Surgeons should be careful to avoid undue trauma to veins, particularly in pelvic and hernia operations. Casts and bandages should not be applied tightly enough to cause venous obstruction. With thrombophlebitis localized in the saphenous vein, ligation of the vessel above the thrombus deserves consideration. As venous stasis is probably the greatest single factor inducing venous thrombosis, every effort should be made to prevent its occurrence. Frequent change of position, elevation of the foot of the bed, muscular activity of the legs and massage have all been recommended. Systematic exercises of the extremities for all postoperative patients were advocated by Richardson in 1904, and various contrivances have been used for this purpose. The routine postoperative use of carbon dioxide to stimulate respiration should also be of value in preventing venous stagnation. Unfortunately, however, it is impossible to prevent the occurrence of cardiac disease and decompensation, as well as the development of suppurative conditions—particularly abdominal. These two important causes of venous thrombosis will always be responsible for a certain number of pulmonary emboli. Some of the procedures which have just been mentioned, although employed to prevent venous stasis and thrombosis, have the disadvantage of aiding liberation of clots from thrombi which have already formed and which may have been undetected. With any suspicion of such an event, all attempts to promote circulatory activity should be stopped at once. Enforcement of complete rest after the appearance of a small embolus cannot be too strict. Such a regimen may prevent the liberation of a larger and fatal embolus.

TREATMENT

Treatment for the immediate attack does not differ greatly from that employed in coronary occlusion. Complete and prolonged rest in bed must be maintained. The patient will be more comfortable with elevation of the head and shoulders. There is no indication for digitalis. Morphine should be used for restlessness and discomfort. Oxygen is of great value in the presence of cyanosis or air hunger.

A few lives have undoubtedly been saved by the use of the Trendelenburg operation, which consists in removing the embolus from the pulmonary artery. It requires the presence of a trained and equipped operating team at the patient's side the moment the operation happens to be indicated. This may be practical in some large hospitals. It is complicated by diagnostic, prognostic and technical difficulties which will probably prevent its widespread use.

IN CONCLUSION

In conclusion, we would like to emphasize four points. Pulmonary emboli are frequently seen in both medical and surgical patients. They may be confused with coronary occlusion, pneumonia, atelectasis, and other conditions. The emboli are characteristically multiple and recurrent. It is important to remember them in the differential diagnosis of many acute pulmonary and cardiac con-

ditions, and to diagnose the small emboli in order to take the proper steps to prevent a recurrent and fatal embolus.

1136 West Sixth Street.

DISCUSSION

DONALD J. FRICK, M. D. (1136 West Sixth Street, Los Angeles).—This is an excellent and timely review of present knowledge concerning pulmonary embolism. The statistics from both the General Hospital and the Children's Hospital are of extreme value in pointing out an important factor in the production of emboli, *i. e.*, slowing of the blood current. Children, during their illnesses, move about. Their circulation is usually at an optimum. Their heart muscles are competent. As age advances, we have the degenerative changes of the heart muscle, which slow the blood flow both in the periods of shock and mobilization during medical and surgical illnesses.

The realization of the danger of even moderate cardiac damage, plus temporary immobilization of portions of the body, especially the pelvis and the lower limbs, will make us more careful in the handling of all our patients—seeing that the heart is improved to its optimum and passive or active motion of the extremities is made a routine. Thrombi form as a result of retarded blood flow. From thrombi come emboli.

Early diagnosis is a necessity, both from the standpoint of proper treatment and the prevention of later emboli. This point is well brought out, and should at all times be kept in mind in the cure of this hazardous accident.

Every physician, whatever his trend, should have the fullness of knowledge regarding pulmonary embolism, its diagnosis, prevention, and treatment. This emergency will come to all of us, and only by full knowledge can we save lives.

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ROY E. THOMAS, M. D. (1136 West Sixth Street, Los Angeles).—In this paper by Doctors Ware and Bullock, the importance of pulmonary embolism to both surgeon and internist is indicated in the very first paragraph. Any condition which, in a five-year period, is responsible for nearly 250 deaths in a single hospital, deserves most serious consideration.

Most of us, I fear, have been accustomed to consider pulmonary embolism a sequel to some surgical procedure or trauma. The authors show that surgery is responsible for less than one-half the cases in their series, and in the majority of these there was the additional factor of suppurative.

I can add nothing to the preventive measures advocated in the paper, but I would emphasize the importance of avoiding elective surgery in patients past middle life who are known to have impaired circulation. Also, in those cases of thrombosis of the saphenous vein, resulting from trauma or infection, we can urge the ligation of the vein in the groin. These cases are not common, but fatal embolism does occasionally occur when the free end of the snake-like thrombus, which has been waving in the blood stream, breaks off.

Once embolism occurs, the outcome usually depends on the size and location of the blocked vessel and the previous condition of the patient. In addition to the therapeutic measures advocated by the authors, perhaps the immediate intravenous use of papaverin deserves mention. This treatment was advocated by Pal in 1914. If it be true that the point of lodgement of an embolus depends on spasm of the arterial wall rather than on the diameter of the vessel relative to the size of the embolus, then the use of a quickly acting antispasmodic drug such as papaverin is certainly rational. Collins has recently reported a series of ten cases so treated, with only one fatality. This would be encouraging, indeed, if one could be sure that the diagnosis of pulmonary embolism was correct in every case.

In this connection the following case is of interest. A patient was operated upon at the Los Angeles General Hospital for perforated duodenal ulcer. Several days later, while apparently convalescing, he suddenly went into shock, with all the signs of pulmonary embolism. He was given papaverin, grain one, intravenously, with prompt and striking improvement. A few days later an apparently identical attack occurred, which failed to respond

to the same treatment. Autopsy showed no evidence of pulmonary embolism or other pathology to explain the sudden death.

Recently, a patient on one of the medical wards was allowed out of bed for the first time following lobar pneumonia. He walked a few steps and collapsed, with all the classical symptoms of pulmonary embolism. At the autopsy no embolism was found.

I cannot close this discussion without a word of condemnation for the Trendelenburg operation. I quote Evarts Graham: "When one considers the chance of error in wrongly interpreting the symptoms, and, therefore, in making an erroneous diagnosis of pulmonary embolism, the possible enthusiasm for the operation necessarily wanes. Still more must one's enthusiasm diminish when it is considered that not only is it necessary to establish a diagnosis of pulmonary embolism, but also to determine that in the particular case the embolism will prove fatal unless the operation is performed. Every surgeon of large experience has occasionally seen patients recover spontaneously in cases of embolism which seemed at the outset as if they would be fatal. After all, the operation is a very serious procedure. Considering these facts, one cannot help wondering whether, if it gains popularity, more patients will not die from the operation than would die from pulmonary embolism alone."

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PHILIP H. PIERSON, M. D. (490 Post Street, San Francisco).—Doctors Ware and Bullock have made a very thorough survey of the question of pulmonary embolism and have supplemented this study with a careful investigation of considerable autopsy material.

There are two points which I would like to emphasize: first, sterile emboli often go into normal lungs without any complications save for a transient spike of fever and local congestion, which quickly clear. On the other hand, when a sterile embolus is lodged in a congested or infected portion of the pulmonary field, trouble generally develops. I think a great many small, sterile emboli lodge in the lung, and we have no knowledge of their occurrence.

The second point that I would like to add is that, after a lung has been compressed for some time by fluid, small thrombi often form in the pulmonary vessels. If a large amount of this fluid is evacuated at one time, in these long-standing cases, emboli are at times set free and either cerebral or visceral damage takes place. It is safer then, in long-standing fluids, to take off not more than 500 to 700 cubic centimeters at a time.

PSYCHOSIS IN THE MENTALLY DEFECTIVE*

By F. O. BUTLER, M.D.
Eldridge

DISCUSSION by Ruggles A. Cushman, M.D., Talmage; Edward W. Twitchell, M.D., San Francisco.

PSYCHOSIS is a much more frequent complication of mental deficiency than is generally believed. Frequently a patient, who comes to the attention of the court or the doctor because of peculiar actions or inability to adjust in the community, is given a mental test, and when found to be subnormal is dismissed as feeble-minded and all his symptoms ascribed to this condition, while in reality he may also be suffering from a psychosis, and it is the psychosis that is causing his inability to adjust. He may have been getting along well enough until his mental upset occurred. This patient needs the care afforded by a mental hospital. If he is returned home his difficulties

* From the office of the Medical Director, Sonoma State Home.

Read before the Neuropsychiatry Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

continue, while if he be sent to an institution for mental defectives or to a boarding school he will not fit in with other defectives and will continue to be a problem until he finally is sent to a mental hospital or recovers from his psychosis.

LIMITATIONS OF INSTITUTIONS FOR THE MENTALLY DEFECTIVE

Institutions for the mentally defective are not equipped to care for psychotic aments. The majority of the patients at such institutions require custodial care and training from which the disturbed patients cannot benefit because of their mental condition; while their behavior taxes the facilities of the institution in caring for them and disturbs the routine of the ward on which they are placed. These patients frequently keep those otherwise well behaved in an uproar, and are unsatisfactorily treated because the attendants are not usually trained in the care of psychotic patients.

DETERMINATION OF THE MENTAL STATUS IMPORTANT

Therefore, in order that our state and private institutions may function at their best, care should be taken to ascertain the exact mental status of a person before it is decided where he should be sent. Merely because he has a low intelligence quotient does not mean that his chief complaint is mental deficiency.

True, it is difficult to be sure just what ails a patient seen in the detention home, and who can be observed only for a short time before his disposition is decided upon. However, a trained psychiatrist can be fairly sure of his diagnosis, and will avoid many more errors than can a person whose practice encompasses chiefly other fields of medicine. Therefore, it would be well for the judge or person who has the disposition of the case in hand to have a competent man see the patient and give him a chance to observe him and be guided by his recommendation.

With reference to the mental rating arrived at by a psychometric reading, it must be remembered that a person with normal mentality will, when acutely disturbed, or when the condition is due to deteriorating mental disease, test in the feeble-minded group. While his intelligence quotient fits in this group, still he should not be treated with that group because his intelligence quotient is the result of, and not the cause of, his trouble.

TWO STATE INSTITUTIONS FOR THE MENTALLY DEFICIENT IN CALIFORNIA

There are two state institutions for the mentally deficient in California—one situated in northern California, at Eldridge, which was established in 1887 in another part of the state, and which on April 1, 1936, had an actual population of 2,630, representing an overcrowding of 21 per cent. The other state institution is situated in the southern part of the state, at Pacific Colony, and on April 1, 1936, had an actual population of 734, representing an overcrowding of 18 per cent. The total population of the two institutions on this date was 3,364. Also, there is a long list of over 2,000 patients awaiting commitment to these two insti-

tutions, and there are numerous private homes for the care of such children, while many are cared for in their own or foster homes.

THREE MAJOR GROUPS OF PATIENTS

The great majority of these patients may be divided into three large groups:

The obviously defective, who for one reason or another cannot be cared for in their community;

The epileptics;

And the defective delinquents who are sent here rather than to prison or correctional school.

Forming a fourth much smaller group, but still large and troublesome enough so that they are demanding ever-increasing attention, are the psychotic aments with a problem all their own. Because they are psychotic they do not belong among the stable and adjusted feeble-minded, nor, because of their basic deficiency and frequently their age, do they belong among the adult group cared for in state hospitals. A special institution for their care is a pressing necessity, which we hope will be met in the near future.

Aments fall heir to the same psychoses found among the general population. Due to their short-life expectancy, emphasis is placed on those psychoses prone to occur in adolescence and early adult life. Also these patients are subject to many transient periods of mental upset which cannot be readily classified, and which are accordingly labeled psychoses associated with mental deficiency. While all the recognized types of psychoses occur in aments, their symptoms and signs are frequently considerably altered because of the associated deficiency. However, the same etiologic factors and symptomatology are in evidence here as they are among mental patients who are not defective.

DIAGNOSIS OF TYPES OF MENTAL DISORDER

Diagnosis of the type of mental disorder is complicated by the degree of defect present. In the lower grades, only actions are available as guides to what is the condition of the mind, as the patient is very frequently unable to give the examiner information in any other way. Thus, it is largely a matter of clinical judgment as to what type of psychosis is present. The higher the intelligence quotient, of course, the more nearly the problem approaches that found in the normal population.

As to whether the patient has a definite major psychosis grafted upon his amentia, or whether it is merely a minor psychotic episode associated with the deficiency, depends upon the character of the behavior and the duration of the upset. Many of the feeble-minded have transient periods of psychic upheaval, varying from mere temper tantrums to definite psychotic episodes of short duration or to definite major psychoses.

Because of the peculiar actions of the idiot and imbecile, and the childish behavior of the morons, it is sometimes very difficult to say whether his behavior is normal for him or if he is suffering from a psychosis.

SURVEY OF THE PSYCHOSES AT SONOMA STATE HOME: JANUARY, 1930, TO JANUARY, 1936

A survey of the psychoses that have occurred at the Sonoma State Home from January, 1930, to January, 1936, shows that almost every type of psychosis tabulated by the American Psychiatric Association is there represented.

ENCEPHALITIS SEQUELAE

Of chief interest, because it is a most recent development, is the large number of cases which are the result of encephalitis with personality changes in the individual. These patients very frequently are normal until they have lethargic encephalitis, influenza, or some childhood disease. After recovery they become quite different people and are profound behavior problems. These patients undoubtedly have organic brain damage, but so far there has been very little material available for study. Their intelligence quotients remain high, but their emotions are profoundly altered. While these patients are not feeble-minded, because of their age group—usually under twenty—they are found more and more frequently in our institution because there is no place else to care for them.

Such cases are diagnosed chiefly on the behavior, which includes usually lying, stealing, sex delinquencies, extreme cruelty, resentment of all authority, total disregard of punishment, a complete candor in recounting their behavior with an emotional reaction of complete indifference and a total inability to explain why they act as they do. The history is sometimes barren of evidence of just when the encephalitis occurred. Also the neurologic evidence is usually slight and characterized by the spotty distribution of the lesions. The most familiar sequela of encephalitis, Parkinson's syndrome, is not usually found in this group. We believe that many cases placed in other classifications, especially that of psychopathic personality, really belong in this group and that these cases will assume an ever-increasing medical problem.

From January 1, 1930, to January 1, 1936, a period of six years, there have been 510 patients referred to our psychiatrist because of peculiar behavior noted in the institution. Of these cases, 287 have been found to be suffering from some form of psychosis.

PSYCHOSES BY GROUPS

1. The commonest psychoses were found to be those associated with epilepsy. As the institutions caring for the mentally deficient are the only institutions in the state caring for nonpsychotic epileptics, a large part (approximately 25 per cent) of our population is made up of these unfortunate sufferers. It is only to be expected that a group suffering from this profound nervous disorder would develop a considerable number of psychotics. The commonest mental picture is that of deterioration, a gradual development of mental dullness, slowness of association and thinking, impairment of memory, irritability, or apathy. Various accessory symptoms, paranoid delusions

and hallucinations, may be added to this fundamental deterioration. These patients are the slow-moving, thick-speaking, irritable individuals, frequently seen. They do not present much of a problem unless their hallucinations and delusions lead them to attack their fellows, when they must be segregated.

The second type of epileptic psychoses, the epileptic clouded states, is characterized preceding or following convulsive attacks by dazed reactions with deep confusion, bewilderment and anxiety or excitement, with hallucinations, fears and violent outbreaks. These are the dangerous type as, during their confused periods, they do many impulsive acts that frequently cause injury to others, and of which the patient is wholly unconscious and for which he develops a complete amnesia.

Other epileptic types of psychoses show paranoid trends, hallucinatory states, depressions, elations, and manic attacks, with few other manifestations.

The prognosis in these cases is, of course, grave. They continue steadily downhill; and, while the psychotic episodes may be brief, they tend to recur and be prolonged.

The epileptic psychoses comprised 24 per cent or almost one-fourth of our psychotic patients.

2. The next commonest group are the dementia praecoxes, which comprised 17 per cent of our psychoses. While it is difficult to differentiate between the brief upsets frequently met with in defectives and a true dementia praecox psychosis, true schizophrenia does occur in defectives, even in the lower types where it might be thought it would not occur. In fact, when first seen, it is often hard to be sure whether the patient is primarily defective or if he has always been a praecox and has been sent to us on the basis of a low intelligence quotient due to deterioration or pre-occupation resulting from the psychosis.

The various types occurred in the following frequencies: simple, three cases; hebephrenic, forty-two cases; paranoid, two cases; catatonic, two; unclassified, two. The only difference between these cases and those met with in mental hospitals is that the patients are more inaccessible and do not show the strikingly bizarre features so frequently seen. They are more frequently characterized by and diagnosed on their typical behavior so rich in mannerisms with evidences of hallucinations. Aside from the paranoid types they do not present a serious problem, as they are much better workers than the purely defective and fit in very well.

3. The third largest group includes those called psychoses associated with mental deficiency. These are usually of an acute transitory nature and most commonly have episodes of excitement with depression, paranoid trends, and hallucinatory attacks. The attacks are brief, frequently being readily brought on by minor events in their environment, and are usually readily controlled. They may be likened to the temperamental outbursts of the spoiled child, but are more deep-seated. These comprise 16 per cent of our cases.

4. The fourth group are those best grouped under the heading of behavior disorders. Our institution receives a large number of defective delinquents, many of which are found to have a definite organic basis for their behavior. They compromise 10 per cent of our series. They are caused by encephalitis, either the lethargic type or that associated with childhood diseases. In some cases, even though there is no history, the behavior is so typical that they are grouped here. Causes of these thirty-two behavior problems were as follows: lethargic encephalitis, measles, influenza, pneumonia, and pertussis. Patients presenting the typical Parkinsonian picture occasionally have associated behavior disorders, and also become frankly psychotic. The commonest psychosis in this latter group is a psychoneurosis. However, depressions and melancholias are also found. Evidence of deterioration also occur in a few cases.

This group presents a serious problem in their care and training, as discussed elsewhere.

5. The fifth group is that of the manic depressive psychoses, which comprise 6 per cent of our series. This psychosis occurs in the higher groups and more frequently are represented by the manic phase than by the depressed phase.

This group is a complete misfit in our set-up, and must be segregated early to avoid damage to themselves and to others.

6. The sixth group is that of the psychoneuroses, comprising 5 per cent of our series. They represent the usual features and occur among the higher grades of our patients, as would be expected. They are serious problems and cannot be well cared for here.

Psychopathic personalities comprised 5 per cent of our cases, and of these only one-fourth had periods of upset which placed them as definitely psychotic, while the rest were made up of sexual pervers and emotional abnormalities.

SYPHILITIC AND ALCOHOLIC FACTORS

Syphilis played a part in only 4 per cent of our psychoses, and of these only one-third were juvenile paretics. Trauma accounted for 2 per cent of our cases, three cases showing post-traumatic personality disorders and two cases showing post-traumatic mental deterioration. Psychoses were associated with somatic disease (tuberculosis) in two cases, and there was one case of senile psychosis developing in an old defective who had spent the greater part of her life in our institution.

Among the psychoses we did not see were the alcoholic psychoses and the involutional melancholias. Alcoholism plays a minor rôle in the lives of our patients as we see them. Their drinking habits are due to the effect of their environment on their mentality, and alcoholism is only an incidental feature, seemingly taking no deep hold upon them.

The intelligence of this entire group of 287 cases by psychometric examinations showed a range from the idiot to the normal, as per our psychologist's report in his routine examinations on admission and some on reëxamination, as indicated.

GENERAL CLASSIFICATION

The following were the general classifications as we group them with the range and average intelligence quotient:

TABLE 1.—General Classifications With Range and Average Intelligence Quotients		
	Range	Average
Psychopathic personalities	52-89	70
Lues	49-57	53
Psychoneurosis	73-90	80
Dementia praecox	26-70	60
Manics	20-72	45
Epileptics	41-94	70
Behavior disorders	41-90	70
Psychosis associated with mental deficiency	9-70	60

Thus indicating that mental disease may be expected in any degrees of mentality, and the lower the mentality the more difficult it is to make a differential diagnosis.

TREATMENT

In general, the treatment of psychotic aments is the same as that for other psychotic patients. However, there are one or two points that I would like to stress:

First: Since the mentally defective is, on the whole, a young group, many or most of the psychoses occur in patients under twenty. For this reason, as well as the fact that any degree of amentia may be present, they are rendered misfits in mental hospitals. There should be a special ward or wards attached to mental hospitals where these patients could be cared for, and in which they could be properly segregated. When this step is taken, we will have solved, in a considerable measure, the problem of the care and treatment of these patients.

Second: The rapidly growing group of personality changes following encephalitis do not, at present, fit anywhere in our scheme of treatment. They are not psychotic in the way that most mental hospital patients are, and they are usually not yet adults and thus do not fit in the institutions for adults. Also, they are not necessarily feeble, often having a high intelligence quotient, and thus they do not fit with the regular defective type. Again, they are such behavior problems that they are difficult to care for in an institution for mentally defective patients. The pressing need at the present time in California is a group of wards devoted to the care, according to their age group, of these postencephalitic patients.

The treatment of these patients is, as yet, only in the experimental stage. There are several clinics in this country working with these patients, and, while a few cases appear to recover and adjust satisfactorily, there is always a chance that these are only temporary cures, since many patients will do well for a few months, usually about six, and then return to their former behavior. This seems to be due to their inability for sustained interest in their environment and activities. The main plan of attack is one in which the child is removed from his home environment and placed

in a special school with twenty-four-hour supervision, with a strict regular routine and frequent changes of activity throughout the day. These children are naturally nonconformist and must be made to conform; but the method by which this can be done varies in each case. Punishment, as such, has little effect and should be discarded. In their homes these patients have been the subject of much undesirable personal attention because of their behavior, and have been singled out from the rest of the family. The bad effects that this treatment has had on the child must be overcome.

DISPOSITION OF THE PATIENTS AT SONOMA STATE HOME

The disposition of these patients up to this time might be of interest, as we are all concerned with the end-results of our treatments, whatever they may be.

TABLE 2.—Disposition of the Patients at the Sonoma State Home

	Per Cent
Transferred to other institutions	48
Retained (due to psychosis being mild, or where we feel their deficiency predominates over their psychosis)	49
Transferred and returned, as recovered from their psychosis or greatly improved and their deficiency only remains or at least predominates over their psychosis	1.3
Paroled	1.2
Died	0.5

This group have little or no sense of right and wrong, and do many impulsive things that result in harm to others. For this reason they should be segregated indefinitely until it can be ascertained that their antisocial tendencies have been curbed. Also, they need routine schooling. They are so regularly excluded from school that schooling must be provided in a special class and institution, for the facilities for the proper care of these patients and the psychotic defectives in California have yet to be provided.

Sonoma State Home.

DISCUSSION

RUGGLES A. CUSHMAN, M. D. (Mendocino State Hospital, Talmage).—We who are attempting to care for psychotic patients in the State hospitals are intensely interested in the problems of mentally defectives. While we do receive those mentally defective patients who are transferred from the homes for the feeble-minded, correction schools, etc., all psychotic patients we receive from the various counties, if they are not already mentally defective, soon lapse into that condition, after more or less of an interval, as a result of their mental storm. This defect in their mentality is almost invariably continuous. With some, of course, the advance is slow; so that after patients with this psychosis have sunk to a certain level they remain practically the same, with a more or less modified deterioration as the years go by.

Every one of these psychotic patients, after one such mental storm, never completely resumes his former mental powers. Owing to the inability of the relatives or friends of the patients to provide suitable homes, they become wards of the State. The reader may be interested in knowing that at the present time we have approximately 25,000 of these wards scattered throughout mental hospitals, homes for the feeble-minded, correction schools, etc. Quite a proportion of these patients have been under the care of the State for many years. For instance, here at Mendocino we have seven patients who have lived in this

hospital between forty and fifty years. We have approximately twenty-five who have lived here from thirty to forty years. The probability is that our average time for residence in this hospital with all patients is approximately ten years.

This all involves a tremendous expenditure on the part of the State, as, with the practice of the utmost economy, we are compelled to spend around \$225 each year per capita. In other words, the Legislature appropriates each session for the support of State hospitals for the biennium approximately \$14,000,000.

It may also interest the reader to know that the sum total of admission for all State hospitals represents a turnover of approximately one thousand patients per month. The admission of new patients and the return of old patients from parole is approximately one thousand; the discharge and parole and deaths amount to around nine hundred, leaving a surplus of about one hundred scattered throughout the various State institutions. This means that there is a steady increase in California of around one thousand patients each year who have to be provided with a suitable home and proper maintenance. This condition has caused excessive overcrowding. None of the institutions have sufficient bed capacity to care for their inmate population, making it necessary in each hospital to have some patients sleep on the floor. Up to the present time it has not been possible to overtake this excess by the erection of new buildings, so that one may readily see the problem confronting all those interested in the proper care of these State charges.

We who are engaged in State work are trying to place these psychotic and defective patients in such a bodily and mental condition that they will be capable of adapting themselves to their surroundings and conforming in action to the usages of society in so far as may be possible.

You will realize from the above that I have viewed this subject, not so much about psychoses developing in the mental defective, as I have the defectives who run along with our psychotic condition. We are aiming to get these patients out at the earliest possible date, back to homes and relatives, with a different view of life as will cause them to have less conflict in their contact with other people, even though they may be fundamentally in the mentally defective class.

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EDWARD W. TWITCHELL, M. D. (909 Hyde Street, San Francisco).—It may no doubt surprise some to learn from Doctor Butler's paper that the mentally defective may become insane. But a moment's reflection should show that just as the stupid normal may become insane, so may those who are even more stupid, and that, as a matter of fact, no degree of stupidity protects one from insanity. But the lower one goes in the mental scale the more difficult may it become to determine when the feeble-minded become insane, while a feeble-minded patient who has been docile and manageable may, by reason of a psychosis, be converted into one who is far from manageable.

Under such conditions these patients naturally add to the difficulties already great enough in dealing with mental defectives, and some way must be devised for segregating them, otherwise an entire group of inmates under good control may get out of hand. The only thing to do is to place them in a separate ward or in an institution for the insane. Now, a home for feeble-minded, not being designed for the treatment of the insane, has added responsibilities placed upon it which should be avoided if possible.

In hospitals for the insane, one of the difficulties is that so many of these patients being children, they cannot well be put in wards with adults. It is not likely that the idea of a separate institution for psychotic aments would find favor in these days when there is so much difficulty in providing funds for institutions already existing.

The most practical way out would undoubtedly be to set aside wards for psychotic aments in the State hospitals for the insane. The epileptic who becomes psychotic is always a particularly difficult problem by reason of the tendency to do violent things, and some terrible things have been done by epileptics in a postconvulsional haze. The encephalitics with character change began to show themselves as a problem soon after the great epidemic. They were especially not easy on account of the fact that

they were at times so apparently normal and it was hard to convince their relatives and friends that there was anything wrong with them.

As Doctor Butler has shown, practically all types of mental disease can be found among the mentally defective, and treatment will follow the same line. It seems to be generally admitted that the juvenile paretics fail to respond to pyretotherapy as well as do the adults.

It is well that a situation already common knowledge to those in the institutional world should be brought to the notice of the profession in general.

TRANSURETHRAL RESECTION: DOES IT REQUIRE AS EXACTING A PREOPERATIVE PREPARATION AS PROSTATECTOMY?*

By H. C. BUMPUS, JR., M.D.

AND

BEN D. MASSEY, M.D.
Pasadena

DISCUSSION by H. A. R. Kreutzmann, M. D., San Francisco; A. M. Meads, M. D., Oakland; J. C. Negley, M. D., Los Angeles.

THROUGHOUT the development of prostatic surgery, overemphasis of some particular type of operation or of some special phase in the preparation or the after-care of the patient, has characterized discussions of the subject. The pioneer surgeons earnestly debated the relative merits of partial and complete enucleation. The next generation heatedly argued the advantages and disadvantages of perineal or suprapubic prostatectomy. Today we are involved in acrimonious discussion of a still newer method of treatment. Such divergence of opinion is indicative of a healthy situation. For, when once all are in agreement upon any subject, progress is likely to cease.

THEORY

At the turn of the past century the techniques of prostatectomy were as numerous as the surgeons who attempted it, and results were extremely unsatisfactory, mortality running as high as 90 per cent. Improvement in this situation was brought about by recognition of the importance of preoperative treatment. The main factors contributing to this improvement were: (1) The practice of preliminary drainage; (2) the development and application of tests of renal function; and (3) a realization of the importance of the control of infection.

The exact time when the importance of preliminary drainage was first recognized is not known, but in the initial volume of the *St. Paul Medical Journal*, dated 1889, Arthur T. Cabot, in an article entitled "Drainage of the Bladder Through a Catheter in the Urethra," wrote as follows:

It is often surprising to see how quickly the character of the urine changes for the better under this treatment. Let us take now an even more serious case, in which the obstruction in the prostate has led to a dilatation of the ureters and pelves of the kidneys. With this condition is usually associated a more or less pronounced degree of interstitial nephritis and consequent interference with the excretory function. The urine under these circumstances

is abundant, but of low specific gravity. An inflammation which starts in the bladder of such a patient quickly extends up the dilated ureters to set up a pyelitis, and if relief is not afforded, the substance of the kidney is presently affected and a pyelonephritis is the result. It may be readily believed that a provision for the constant escape of the urine as fast as it reaches the bladder will do much to hinder or prevent this bacterial extension of the inflammation, and experience justifies this belief."

Consequently the practice of gradually emptying the overdistended bladder naturally gained favor and, in 1903, Guyon advised "to gradually and aseptically empty the overdistended bladder."

Thirty-four years of clinical experience and research have done little but confirm this trite observation so far as the advantages in respect to elimination are concerned. Until there is an unobstructed outlet, it is apparent that fluid intake as well as output must be limited; but once the outlet is rendered constantly open and unobstructed by use of a catheter the intake of fluid can be at once increased, and the better elimination of retained toxic substances can be brought about.

As a result of the definite improvement noted in those having diminished renal function and extensive infection, the idea became gradually fixed that all patients with obstruction at the neck of the bladder, accompanied by residual urine, should receive preoperative drainage of the bladder. This was usually accomplished by an inlying urethral catheter, and the idea became so firmly established in urologic minds that to attempt a prostatectomy without a period of preliminary drainage was looked upon as rank heresy. It was noted, however, that in the extremely debilitated this procedure did not always bring the desired results; and that if one wished to prepare the worst risks for operation it was, on the whole, safer to do a preliminary cystotomy and allow the patient to wait an indefinite period before undertaking the enucleation of the gland. Those who practiced this procedure were accused by their competitors of killing off the bad risks by suprapubic cystostomy and thus not being obliged to report them in their statistics of prostatectomy. However, it became evident to the thoughtful and observant that this method of treatment enlarged considerably the number of cases that were ultimately fit for operation, and Doctor Stevens, in charge of the Bellevue Hospital Urological Service, after adopting it as a routine procedure, lowered the mortality rate of prostatectomy in that hospital by more than 25 per cent. As a result, the two-stage prostatectomy became an accepted procedure for the poorer type of risk.

PRACTICE

It has always been difficult for the authors to understand why a surgical procedure, which is admittedly safer for the poorer risk, is not proportionally safer for the average case. We hear the same line of reasoning today among those who advocate resection for the extremely poor surgical risk, but reserve prostatectomy for the average case. Obviously multiple operations were not popular if a single operation could be made to do the work, and so every effort was made to prepare as many patients as possible by using an in-

* Read before the Urology Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25 to 28, 1936.

dwelling urethral catheter. However, this method of treatment gave rise to many complications not often emphasized. It had been observed in the two-stage operation that the prospective operative field was kept at complete rest following cystostomy, which in itself was the surest method of reducing infection in that area to a minimum. The prostate also diminished in size, often to such a degree that the amount of tissue obtained at the second operation was disappointing from the standpoint of bulk, and if secondary infection occurred, it usually limited itself to the bladder and did not result in pyelonephritis; but in the case of urethral drainage it was found that many of these patients had a latent prostatitis which became reactivated by the irritation of the urethral catheter. If the patient had an already impaired renal function, such an activated infection sometimes resulted in a pyelonephritis of sufficient severity to throw him into uremia, especially if the catheter became occluded and the bladder overdistended, which frequently occurred if the maximum of nursing care was not exercised. Furthermore, the presence of the catheter in the posterior urethra was often so irritating that instead of the gland diminishing in size as a result of the relief of the obstruction, it actually increased from the secondary engorgement incident to the trauma.

Cabot and Meland reported in 1933 the effect of inlying urethral catheter drainage uncomplicated by extraneous infection. Of seven hundred patients under observation during the years 1926, 1927, and 1928, they excluded all who developed fever when they first came under observation, all who had fever which might have been attributed to a cystoscopic examination, all patients with acute epididymitis, and, finally, all with any pulmonary complications. This reduced the group to 140 patients. On the average, these 140 patients, submitted to inlying urethral catheter drainage, developed within five days a fever lasting seven and one-half days, and sixty-three of these patients showed a decline in renal function as measured by phenolsulphonephthalein.

Theoretically, it may be that such febrile attacks, as reported by Cabot and Meland, result in immunization of the patient against postoperative infection, but practically his hemoglobin is lower, his weight less, his renal function diminished, and his appetite gone. He is, therefore, a greater surgical risk than he was prior to the insertion of the inlying urethral catheter. Such preparation is obviously of doubtful value, no matter what type of surgical treatment is to follow, and should, we believe, be reduced to a minimum. It should never be continued for a prolonged period.

When complete enucleation of the prostate was to follow this method of preparation, the reactivated inflammatory process in the gland was not always of serious moment, for with the removal of the gland *in toto* the original source of the infection was also removed, and the residual inflammation was given adequate drainage facilities through the suprapubic tube.

In the case of transurethral resection, conditions are entirely changed. Instead of being completely removed, only that portion of the gland which is obstructing is resected, and so there is left *in situ* the infected and engorged portion, a potential source of systemic infection and a probable source of immediate ascending infection; for in the case of transurethral resection no adequate drain is available in the form of a suprapubic catheter. If to this regrettable situation is added the fact that the resection has been carried out with a cautery loop which so effectually seals the entire surface for several days that all bacteria and their toxic products are prevented from any possibility of drainage, the wonder is not that these patients have a relatively short hospitalization, but that so many of them escape a generalized urinary sepsis.

This newer conception of the limitations of preliminary preparation leaves a much smaller group requiring any treatment before operation, and logically increases considerably the number of patients having cystostomies. Once the bladder has been opened, many urologists feel it is illogical to perform anything but a suprapubic enucleation as the second stage. If such enucleation carries the same mortality rate that transurethral resection does, this cannot be questioned, but figures do not bear that out. Large series of cases are now on record indicating that a mortality of 6 to 10 per cent is the best that may be expected from suprapubic enucleation, while there are over 5,000 cases recorded of transurethral resections with a mortality of less than 2 per cent. This indicates that transurethral resection, being a procedure of lessened risk, must be applicable to a larger group. In a report of 2,089 cases with prostatic symptoms, Alcock reported 5 per cent to have died without any surgery, showing in figures for the first time what a large group was refused treatment because of the risk of prostatectomy. Where formerly his prostatectomy cases averaged sixty-six years of age, the patients upon whom transurethral resections were performed averaged seventy-three years. The fact that transurethral resection is a less dangerous procedure made this possible, and, being a less dangerous procedure, it can be undertaken in cases where prostatectomy would not be justified. Hence, a preliminary preparation equal to that required for prostatectomy is unnecessary, for the patient need not be in as fine physical condition to survive the safer procedure. Moreover, as we observed earlier in this paper, the essence of all preliminary treatment is drainage or the removal of residual urine by some mechanical means. The accomplishment of this was presumed to result in the gradual improvement of the patient until he reached a sufficiently good physical condition to make operation justifiable.

With transurethral resection the eradication of residual urine is accomplished usually in less than an hour's time, and the patient, emptying his bladder without the aid of mechanical means, will naturally improve more rapidly in the restoration of his renal function and elimination of his infection. This could not have been expected if he were compelled to wear a suprapubic tube or an

indwelling catheter. In other words, the resection replaces the preliminary preparation in a majority of cases.

Since entering private practice eighteen months ago in Pasadena, we have followed this procedure. A review of the seventy-one private cases of prostatic obstruction which we treated by transurethral resection shows that 80 per cent received no preliminary preparation. Thirty-eight per cent of the group was over seventy years of age. The average period of hospitalization was less than one week. There was one death, occurring on the thirty-fifth day following an epididymitis—one of the few cases in which ligation of the vas deferens was not done. While this series is naturally not large, this same trend in the abandonment of preliminary treatment in resection is borne out by the Mayo Clinic figures for last year, when Doctor Thompson and his associates did 765 resections with but seven deaths, 65.7 per cent of the cases receiving no form of preliminary drainage.

In large clinics with well-organized, specially trained nursing staffs, the methods of treatment will of necessity vary from those imposed upon the individual who must work in different hospitals and depend entirely upon routine nursing. Thus, we find that in the Mayo Clinic series but 3.9 per cent of the patients received suprapubic drainage prior to resection during 1935, and Alcock had used it in only thirty of his 1,400 resections, an incidence of 2.1 per cent, while in our private practice we have employed it in 16 per cent of our resections.

In private practice without the help of a specially trained personnel, obstruction of an indwelling urethral catheter may have most serious consequences, not alone in the activation of latent urethral infection and in the production of pyelonephritis, as referred to earlier in this paper, but also in the causation of bleeding following resection. For this reason we believe that a safety valve in the form of a suprapubic tube is invaluable as an assurance of success. The establishment of such drainage we do not make a major surgical procedure, but usually insert the tube through a small suprapubic incision without opening the prevesical space. If treated in this fashion, even patients of advanced age can usually be up and about the following day. Thirteen patients, or 18.1 per cent of our patients, received suprapubic cystostomy. Their average age was seventy-one years. These thirteen patients had an average removal of 26.8 grams of tissue, and total time spent in the hospital for cystostomy and resections averaged twelve and one-half days per patient.

CONCLUSION

The advent of transurethral resection has not only diminished the necessity of preliminary preparation in the majority of cases of hypertrophy of the prostate, but has increased the number of patients for whom the surgical relief is feasible.

112 North Madison Avenue.

DISCUSSION

H. A. R. KREUTZMANN, M. D. (2000 Van Ness Avenue, San Francisco).—There is no question that marked changes in the preoperative care of prostatics have occurred since the introduction of transurethral resection.

It is possible, as Doctors Bumpus and Massey have stated, to operate on some patients with little or no treatment beforehand. The reason is that many come to surgery during the earlier stages of hypertrophy before complications, such as infection, renal damage and general breakdown of the patient, have occurred.

Formerly, these patients were told they had a beginning hypertrophy and were advised to wait until the gland had attained a good size before proceeding to the more formidable operation of either suprapubic or perineal prostatectomy.

We believe that the urologist is justified in removing these smaller obstructions. It saves the patient any future complications; the surgical risk is much less, and there is no need of preoperative preparation, as the authors rightly contend.

Our percentage of immediate operations is not nearly as high as that reported by the authors, as we do not agree that resection replaces the preliminary preparation in a majority of cases. The urethral trauma produced by the resectoscope and the possibility of opening up localized abscesses in the prostate, by the cutting loop, may result in a postoperative cystitis or pyelonephritis. The combination of an acute infection plus operation may produce serious complications, and even cause the death of the patient.

It has also been our experience that an indwelling urethral catheter is not the ideal method of draining the bladder when resection is contemplated. It sets up an irritation, so that bleeding during operation is greatly increased. We prefer, whenever possible, to insert a catheter suprapubically by means of a trocar.



A. M. MEADS, M. D. (251 Moss Avenue, Oakland).—The preoperative preparation of the resectoscopic patient has been more or less a matter of individual opinion, and a free discussion will undoubtedly be helpful. Like many others, I have followed the leader in the treatment of those coming for relief from prostatic obstruction, but of recent years it has gradually dawned upon me that probably the preoperative care in such cases has been overdone. In six individuals, over a period of years, with acute hemorrhage from the prostate, in which the clot-distended bladder demanded an immediate operation without any preparation, a suprapubic prostatectomy was followed by uneventful recovery in five instances, the sixth dying because of self-imposed delay. Meanwhile, we had been noticing that under the long preoperative routine with the indwelling catheter or suprapubic drainage, the treatment was often accompanied by pyuria, temperature, epididymitis, and occasionally fatal pyonephrosis. In many instances these complications must have been due to too much preoperative care, especially where the urine, the renal function and the blood chemistry were normal, when first seen.

There is no doubt that emphasis upon preoperative care has been primarily responsible for reduction in the mortality following all forms of prostatic surgery in the last thirty years; but to apply a rigid routine to all cases, as has been advised by many in the past, has proved to be a mistake which is now being recognized. When one sees, at a large clinic, a patient enter the hospital on Saturday and resectoscoped on the following Monday, one cannot help but wonder if his own long preoperative routine has not only been unnecessary, but harmful. A reflection of this opinion is seen in the recent plea for intermittent catheterization in preoperative care to replace the indwelling catheter. I have always felt that a prostatectomy and a resectoscopic operation were major procedures, and that short cuts in the preoperative care would lead to postoperative difficulties where a long preparation was necessary. I still think that, given two cases equal in every respect, the preoperative preparation for both should be the same, regardless of the type of prostatic surgery decided upon. We study each case, regardless of the methods of operation to be used, individually, and a rational preoperative program is carried out on the basis of the gen-

eral physical condition, blood chemistry, renal function, blood count, cardiovascular condition, etc.

It is difficult to compare statistics of one urologist with those of another. Each one has his own idea as to which case is to be resectoscoped and which is to be relieved by prostatectomy. It is our custom to bring the patient up to his best by preliminary treatment, and then decide—according to the type of obstruction—what procedure should be followed out to give the desired relief.



J. C. NEGLEY, M.D. (527 West Seventh Street, Los Angeles).—In discussion of the paper by Doctors Bumpus and Massey, one cannot help but notice that most of their quoted statistics are from great distances, and from the clinics of so-called enthusiastic resectionists. To properly evaluate any surgical procedure one must not choose the top-notch performers, but take a cross section of the average practitioners and their results. What the public and the profession wish to know is, what is going on in our own locality, particularly so since many of these patients of seventy years or over would never live to reach Rochester or Des Moines. I submit the following tables from Los Angeles and vicinity, making contrast as to surgical procedures, preparation, complications, stay in hospital, mortality, etc., between prostatectomy and resection. I have listed, in Table 1, charity patients, and in Table 2, private patients.

TABLE 1.—*Charity Patients: Comparative Findings*

	Prostatec- tomies, 100	Resections, 100
1. Suprapubic drainage.....	98%	6%
Indwelling catheter, preliminary.....	100%	72%
2. Average days of preparation.....	17	12
3. Prostatitis	57%	35%
4. Fever over 100, chills, preoperative.....	8%	6%
Fever over 100, chills, postoperative.....	21%	29%
5. Complete retention	32%	7%
6. Residual urine over 1½ ounces.....	77%	50%
Urine infected on admission.....	91%	78%
7. Kidney damage.....	69%	58%
Stay in hospital (days).....	42	28
8. Deaths	6	11
Uremia and pyelonephritis.....	4	2
Coronary diseases.....	1	2
Shock and hemorrhage.....	1	6
Cholelithiasis	0	1
Mortality rate.....	6%	11%

Table 1 is a résumé of the work of some thirty urologists, and would seem to show:

1. All of them still prefer some sort of preliminary drainage in prostatectomies, and in 78 per cent of their resections.

2. There is a difference of only five days in favor of resections in preparation.

3. Prostatitis is a factor in only 50 per cent of cases.

4. Untoward results of any degree from an indwelling catheter is present only in 7 per cent of the combined methods. More cases have fever, chills, etc., after than before operation.

5. Almost five times as many complete retentions in prostatectomy would seem to compel more pretentious preparation than in resections.

6. Another reason why resections need less preparation is because many of them are done for symptoms rather than for large amounts of residual urine.

7. The large proportion of damaged kidneys (pyelonephritis) shows that many of them may have their fever, chills, etc., from this reason, regardless of what is done preoperative.

8. Resection deaths outnumber prostatectomies, two to one; but most of them were surgical accidents.

Table 2 is a résumé from a large private hospital, representing the work of general surgeons as well as urologists.

1. Difference in figures here is due to the fact that some general surgeons prefer one-stage operations.

2. A difference of only eight days in favor of resection.

3. Again, the untoward results of an indwelling catheter is present in only 8 per cent of combined methods.

4. Complete retentions in prostatectomy, more than two to one, would seem to necessitate longer preparation.

TABLE 2.—*Private Patients: Comparative Findings*

	Prostatec- tomies, 100	Resections, 100
1. Suprapubic drainage.....	75%	3%
Indwelling catheter, preliminary.....	88%	41%
2. Average days of preparation.....	14	6
3. Prostatitis	60%	49%
4. Fever over 100, chills, etc., preoperative	10%	6%
Fever over 100, chills, etc., post-operative	21%	60%
5. Complete retention	14%	6%
6. Residual urine over 1½ ounces.....	23%	21%
Urine infected on admission.....	87%	67%
7. Kidney damage	51%	37%
Stay in hospital (days), average.....	21	15
Deaths, total.....	2	12
Pyelonephritis and uremia.....	2	8
Hemorrhage and shock.....	0	2
Lung abscess.....	0	1
Opiate reaction.....	0	1

6. Impossible to estimate because most of this having been done before admission.

7. As in charity cases.

8. Resection deaths outnumber prostatectomy deaths, six to one, and 75 per cent of them due to pyelonephritis and uremia. The most important factor in this series bearing on preparation is that 73 per cent of the resections were in one day and operated the next; 75 per cent of the deaths falling in this group. Surely, this shows that preparation might have helped.

In conclusion, I would state:

1. Any group of patients of 65 or over, many of whom have myocardial damage, kidney damage, prostatitis, infected urine, distress, etc., cannot be standardized, but must be an individual problem, both as to operation and type of operation. Certainly, one who has reached the prostatic age is entitled to a rest in bed for a week or more before surgery is done, as a reward, if for nothing else!

2. The title of Doctor Bumpus' paper is really a misnomer, as he does not do what is generally known as a resection, but does a Young punch or, in reality, a near-prostatectomy through a closed bladder, in that he does no deep fulguration.

3. In the ordinary bladder-neck obstruction, time is not an important element, nor are they emergency operations; so why make haste from an economic standpoint?

PULMONARY CAVITY: OPTIMISM SUR- ROUNDING ITS INTELLIGENT TREATMENT*

By F. M. POTTENGER, M.D.
Monrovia

DISCUSSION by Philip H. Pierson, M.D., San Francisco; Sidney J. Shipman, M.D., San Francisco; Edwin S. Bennett, M.D., Olive View.

OUT of much discussion, now and then a truth is established which thereafter seems so self-evident that one wonders why it had not been recognized before. But knowledge is evolutionary. Only rarely is a fact promulgated which is not based on some other well-recognized fact or principle which is closely allied to it and which has been previously applied in daily use.

PRESENT-DAY UNDERSTANDING OF CAVITY FORMATION A RECENT CONCEPTION

Cavities have been suspected in tuberculosis ever since the disease has been carefully studied clinically, and have been proved to exist ever since

* Read before the General Medicine Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

the lungs have been studied postmortem. But the full significance of cavity as a focus from which the disease spreads in the body of the tuberculous patient; the manner in which it infects members of the community at large; and the problem which it presents in therapy is a comparatively recent conception. Formerly, when cavities were found in the lungs the prognosis was considered to be grave. In the minds of most clinicians their presence meant the death of the patient. Today, however, many cavities warrant a favorable prognosis under general hygienic treatment alone, and some of the most serious ones may be successfully treated by our newer methods.

An adequate conception of cavity could not possibly have been had prior to the discovery of the tubercle bacillus fifty-four years ago; and our present conception has been greatly influenced by studies made by means of the x-ray. So the real appreciation of cavity is of very recent origin, and specialists are just now giving out their conception to general medicine.

INFECTION SIGNIFICANCE OF CAVITIES

A fact that all medical men should appreciate and one that I desire to emphasize, is that, from the standpoint of scattering infection, any cavity which throws off bacilli (and nearly all of them do) may not only be dangerous to the life of the one who possesses it, but also to society. I say "may be" advisedly, for it is possible to remove most of the danger by properly directing the patient. Under no circumstances would I create unwarranted phthisiophobia among practitioners of medicine, for when they are imbued with fear intelligent interest lags. One of the great accomplishments of the modern crusade against tuberculosis is the mitigation of the fear of the disease, which formerly possessed the medical profession. To say eradication would be putting it too strongly, for fear still lurks in the background and comes out in the open at unexpected times.

CAVITY RESOLUTION AN INDIVIDUAL PROBLEM

From the standpoint of healing, cavities must be considered individually. Not every patient who has a cavity in the lung is going to suffer from metastases and death, whether or no. It is not a matter of fate. Some will heal readily; others with difficulty; others not at all. The presence of cavity means that the patient must be treated with intelligence in order to afford him the best chance of cure, and those living intimately with him the best chance of escaping infection.

Cavities are not only amenable to treatment, but many of them heal spontaneously. This is especially true of the early cavities found in connection with acute exudative tuberculosis, particularly if situated sufficiently far away from the pleura so that their closure is not interfered with by adhesions; sufficiently far from the hilum to avoid the dense unyielding structures which make up the root of the lung; and sufficiently far from the diaphragm to avoid the pull of its repeated contractions. Other cavities will heal, too, but those just described heal quite readily when properly

treated. This group includes many of those which clinicians have reported on favorably since hygienic living, with rest in the open air, has dominated treatment. Such cavities, if improperly treated, however, pass on to a state in which healing is more difficult or impossible of attainment.

FACTORS IN CAVITY REPAIR

Healing of cavity, whether with or without mechanical aid, depends on establishing, on the part of the patient, an adequate physiologic balance plus an adjustment of lung volume to the size of the thoracic cage. Specific resistance is probably nothing more than a heightening and quickening of normal physiologic action. Early in the course of the disease, when the greater proportion of pulmonary tissue is elastic and free from disease, the chief form of compensation is brought about by emphysema, particularly in the adjacent and near adjacent pulmonary tissues. This, together with the limited motion of the side, which is caused reflexly by the shortening of the apical muscles, particularly the sternocleidomastoideus, scaleni and subclavius above, and the crus and central tendon of the diaphragm below, will prove effective in many cases, provided the patient, through physical and psychical rest, reduces his respiratory and circulatory demands to a minimum.

Some of this type, however, will need further aid in order to bring about closure; and others which appear to be far more serious will yield to simple measures.

TUBERCULOSIS SYNDROMES

Tuberculosis is usually first seen by the family physician or by a specialist who devotes his study to some other phase of medicine whom the patient is led to consult because of the fact that the disease masquerades under symptoms which the patient interprets as belonging to a specialty other than that of the chest; for it must be remembered that tuberculosis often shows syndromes which simulate lesions in other organs and systems of the body so closely that we speak of distinct types. The neurasthenic (rundown condition), cardiovascular, gastro-intestinal, laryngeal, bronchitic, influenzal, pleuritic, and hemorrhagic types are all well recognized.

It is necessary for all physicians to be on the lookout when these syndromes present, and particularly if sputum is present, because this usually means a break in lung tissue with bacilli present; and quite often, if the onset is sudden, it means the presence of cavity. The future of the patient and the interests of the family both demand a diagnosis and the immediate institution of the proper treatment, and the application of the rules which protect other members of the family and society.

With this done, we approach both the healing of the patient and the security of those who come in contact with him with confidence. Not unmindful of the fact that tuberculosis may spread from any focus within the body by way of the lymph and blood stream, yet cavity is the focus which carries with it the greatest danger to the

patient, and is the source which furnishes most of the bacilli which infect others, so it is evident that its early detection is important to both the patient and others.

IMPORTANT RÔLE OF THE GENERAL PHYSICIAN IN CAVITY DIAGNOSIS

Since tuberculosis is usually first seen by physicians other than specialists in tuberculosis, if it is to be diagnosed early it must be diagnosed by them. This is not only their duty, but their privilege. In what way can a physician render a greater service to those patients who seek his advice than by detecting and treating such a serious disease as tuberculosis early, when it is curable, instead of allowing it to progress to a crippling and often a fatal termination? and in what way can he render a greater service to the friends of the patient than by protecting them from becoming infected?

There is nothing in the diagnosis of tuberculosis that lies beyond the capabilities of the well-trained physician, provided he assumes the same interest in it that he does in other diseases and, furthermore, provided he develops a proper diagnostic procedure. There should be nothing to prevent him from diagnosing a cavity when present, except a failure to examine sputum and take an x-ray of the chest; and the necessity of these should both be suggested by the clinical history.

IN CONCLUSION

A systematic method of approach, which consists of three procedures: (1) taking a careful history; (2) examining any sputum that may be present by the concentration method or guinea-pig inoculation, if necessary; and (3) the reading of a good x-ray plate should detect tuberculosis in all but the most difficult cases, and in open cavity cases it should detect all. A tuberculosis-minded profession, and a profession with the confidence in itself which its training warrants, should become the greatest factor in the further reduction of the morbidity and mortality from tuberculosis.

Pottenger Sanatorium.

DISCUSSION

PHILIP H. PIERSON, M. D. (490 Post Street, San Francisco).—I feel that this contribution of Doctor Pottenger's is very timely, for it directs our attention specifically to a phase of the disease which we must consider very seriously.

1. It must be remembered that a very large percentage of pulmonary cavities do not give physical signs, so-called silent cavities; and in view of what Doctor Pottenger has said, it is most important to supplement our examination with good stereoscopic x-ray films.

2. Comparative roentgenograms are essential to determine the disappearance of cavities, and in those cases where conservative measures do not succeed, collapse should be instituted before a cavity has persisted too long. This is particularly important in peripherally located cavities.

3. Cavities must be closed before patients are discharged, for even small ones frequently enlarge and disease is spread from this area very rapidly. I want to emphasize this point particularly, because I feel that most readmissions to hospitals and sanatoria are due to the failure to have the cavity thoroughly closed at the time the patient is discharged.

SIDNEY J. SHIPMAN, M. D. (490 Post Street, San Francisco).—In this succinct discussion of pulmonary cavities Doctor Pottenger has outlined the chief factors in the pathogenesis and healing of tuberculous cavities. It is gratifying to find him stressing the well-rounded concept of tuberculosis, as it affects the individual as a whole and his relation to his environment, rather than taking up the question of cavity formation and repair apart from the resistance and general make-up of the patient himself. Too often nowadays the so-called specialist in tuberculosis, as well as thoracic surgeons, consider the treatment of cavities and forget the treatment of the patient himself.

There are two points of view in approaching the problem of active tuberculosis, particularly as manifested by cavity formation, when, as Doctor Pottenger remarks, the sputum generally contains tubercle bacilli. One is the public health concept which requires isolation of the patient or closure of the cavity to prevent the spread of infection. Undoubtedly, from the long-range standpoint this is the more important attitude, as far as the control of the tuberculosis problem is concerned. This, I suppose, is the viewpoint which leads those who treat tuberculosis to strive so vigorously to close every cavity and render every sputum negative, even when procedures adopted threaten to shorten the life of the individual. The other viewpoint considers the longevity of the patient as of paramount importance, even though he may be a menace to his environment until the time of his death because of the unclosed cavity. In connection with this latter view, it is probably well that Doctor Pottenger emphasized the fact that "it is possible to remove most of the danger by properly directing the patient." Herein lies the educational function of the sanatorium and of the physician. It is probable that the proper attitude for practicing physicians today is a lively interest in the public health problem and a wholesome desire to render sputum bacillus-free, if at all possible, without too much menace to the life of the individual. There are, however, even today, few who advocate extensive rib resections and the like in people of advanced years merely with the hope of closing cavities.

A discussion of the specific factors active in cavity repair is of extreme interest. Some of them we know and some of them we merely suspect, and doubtless there are others which none of us have considered. Certainly, we are hard put to it to explain the behavior of all cavities under various methods of treatment. As Doctor Pottenger remarks, some close with scarcely any treatment at all; others remain open in spite of most vigorous surgical measures. All of us have seen what appeared to be a satisfactory pneumothorax in which thoracoscopy showed no adhesions to be present, and yet a small cavity maintained its size beneath the pleura or in the interior of the lung. It might even cause a bulge at its location, which was difficult to explain except on the basis of one-way valve action in the bronchi, as noted by Chevalier Jackson time and again. Postmortem studies of bronchi leading from pulmonary cavities reveal the high rate of tuberculous infection in the walls and numerous partial stenoses. This factor calls for more complete investigation. With a wealth of pulmonary tissue surrounding a cavity, new explanations must be offered as to why collapse does not occur, and undoubtedly new methods of treatment must be devised to obtain satisfactory healing. One of the interesting features of the study of tuberculosis is the wealth of unexplained phenomena which still exists in dealing with this well-known disease upon which so much work has been done since the discovery of the tubercle bacillus over fifty years ago. Doctor Pottenger has done well to emphasize the part which general medical men should play in examining patients for early diagnosis; but I suspect that so-called "chest specialists" may well join hands with them in searching for the answers to so many questions which still remain enigmas to most of us.

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EDWIN S. BENNETT, M. D. (Olive View Sanatorium, Olive View).—I am in entire accord with a feeling of optimism regarding cavity closure in pulmonary tuberculosis, but I should like to emphasize by italics the word "intelligent," as pertaining to the adequate treatment of persons who have pulmonary tuberculosis, regardless as to whether demonstrable cavitation is present in the lungs. Furthermore, intelligent treatment should mean not only

sufficient knowledge on the part of the attending physician, but include his instruction of the patient in order that the patient may become better informed as regards the pathology, care, and after-care of this disease.

Doctor Pottenger quite rightly starts at the beginning in emphasizing that accurate and early diagnosis is essential, and points out as one of his three criteria in making a diagnosis the taking of a careful history. This is strikingly borne out when one realizes that a survey of the records of most large sanatoria will show that, from the history alone, patients when admitted have in all probability had tuberculosis for at least a year and a half. Thus, it is self-evident that history taking is important, and should not be delegated to one who is not a trained investigator.

There is a wide variation in figures as regards the percentage of cavities which close spontaneously, and this is readily understood when one realizes that the size of the cavity and the location in large part determine the outcome in patients who do not receive collapse therapy, as well as those who do. Diagnostic technique has improved in the last decade, until now small intrathoracic cavities may be visualized, which formerly were overlooked. However, it must be admitted that the present technique is not perfect, and that in all probability many cavities which are a menace and harbor great numbers of tubercle bacilli are not now demonstrable by means of any present diagnostic method.

In the intelligent treatment of pulmonary cavitation our efforts are dual, namely, the protection and cure of the patient, and as a public health measure in protecting the contacts. For the sake of the patient and the general public, and for economic reasons, the effort should always be made to close as promptly as possible all cases of open tuberculosis in order that these cases will no longer be a menace to themselves and to others. Thus, the modern and intelligent treatment of tuberculosis is largely a matter of compression therapy. At present no up-to-date sanatorium whose patient population is largely composed of sputum-positive cases is fulfilling its duty to the patient and to the public unless from 70 to 80 per cent of its patient population are receiving some form of compression therapy. Such treatment is not radical, even if begun early, but is simply a proper realization of the problem at hand, namely, making the patient sputum-negative and sputum-free without unnecessary delay. Taken by and large, artificial pneumothorax is unquestionably the greatest aid we have at our command. This procedure alone, or combined with phrenic surgery, will result in cavity closure in a large percentage of cases, with a minimum of risk to the patient. According to the size and the location of the cavity, other procedures (such as temporary phrenic paralysis by crushing, or wax plombage) are often the methods of choice. In recent years, possibly by accident, we have learned that pneumoperitoneum is of therapeutic value, not only for pathology present below the diaphragm, but for unilateral or bilateral pulmonary disease in cases where pneumothorax has not been feasible or possible. In those cases where other simpler methods have failed, a thoracoplasty is indicated, not only for the benefit of the patient, but simply as a public-health measure. However, from time to time patients are seen with a cavity so located that even complete posterior and anterior thoracoplasty will not obliterate the cavity. When such a problem presents itself, at times the only answer is a pneumonectomy with complete extirpation of the involved lung. Radical as this procedure seems now, I feel that within the next five years our knowledge of cases and thoracic surgery technique will improve to the point where this operation will not seem any more radical than did thoracoplasty five years ago.

In all cases of contemplated compression therapy, it is, of course, understood that the patient is entitled to, and must have a careful and complete history, physical examination, and laboratory study, in order to determine as accurately as possible the degree of risk that is involved in any of the procedures heretofore mentioned.

In conclusion, I wish to emphasize that optimism should be the note stressed in the closure of cavitation by intelligent treatment, and we all are indebted to Doctor Pottenger for calling our attention to the fact that we have a perfect right to be optimistic, and that the outlook for the future is becoming brighter all the time.

EXPERT MEDICAL TESTIMONY IN CALIFORNIA COURTS*

By HAROLD DEWEY BARNARD, M.D.

AND

GEORGE E. TUCKER, M.D.

Los Angeles

DISCUSSION by Andrew S. Lobingier, M.D., Los Angeles; Hubert T. Morrow, Esq., Los Angeles; Hartley F. Peart, Esq., San Francisco.

THE frequent contributions to current legal and medical publications on the subject of "expert medical testimony," together with the wide differences of opinion expressed by the contributors, lead the unbiased investigator to conclude that our usual court procedures, as they relate to this matter, have not been and are not now altogether satisfactory.

There may be other methods which might properly be followed if justice is to be obtained in our courts, and both parties to a legal action are to enjoy their guaranteed rights of equality before the law.

One does not need to proceed very far in his investigation of the subject to learn that many representative members of both the legal and medical professions feel that some change should be brought about which will more certainly and equitably serve the ends desired.

WHY COURTS HAVE NOT PLACED EXPERT MEDICAL TESTIMONY ON A SOUNDER BASIS

It is not strange that there should be such widespread differences of opinion among lawyers and doctors as to *what* should be done or the real need for doing anything.

If, under a system of judicial procedure, a staff of attorneys and doctors aligned behind a plaintiff are attacking one goal, while another staff of attorneys and doctors aligned behind a defendant are defending that same goal, in spite of the rulings of the court, it usually follows that the better-trained, stronger team will win the objective.

Trial procedures in our courts, to the uninitiated, too frequently resemble the scenes of a Roman holiday. The interests of justice appear to be overlooked.

Not infrequently counsel and court become so thoroughly enmeshed in the "barbed wire" of legal entanglements that the jury, witnesses, and spectators have difficulty in knowing what it is all about, while Justice, which presumably is to be served by such a procedure, closes her eyes, folds up her scales, lowers her rusty saber, and emerges from the courtroom to await another and more favorable opportunity in which to issue a challenge to the legal rights of members of society.

If such scenes were not so serious and pathetic, and human nature so devoid of humor, they would be looked upon as being nothing other than ludicrous.

* Read before the General Medicine Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

THE DILEMMA OF THE PHYSICIAN IN A PERSONAL INJURY CASE

On those occasions when the doctor, serving as an expert in a personal injury action is drawn into such a picture and called upon to express an unbiased, unprejudiced, truthful opinion regarding the seriousness and extent of a plaintiff's injuries, how in the name of that same justice that is presumed to prevail and govern litigation can an expert be expected to willingly "bite the hand that feeds him"? Once convinced of the merit of a case in which he has been employed, it is only natural that he should, in his desire to be of help and service, become an advocate as well as a witness.

If he is not in the case to help the plaintiff, the court, the jury, and the spectators know that at least he was hired for that purpose. His failure to properly serve the plaintiff's interests is looked upon as evidence of either incompetence or incapability, or, what is more unfortunate, he may even be suspected of "having been reached."

Defendant's experts are in the same relative position with this usual exception—they expect to be paid, whatever the outcome: win, lose, or draw. People who cannot pay are seldom made defendants in such an action. From a financial standpoint, entirely aside from the ethics involved, experts employed on a contingent basis cannot afford to be too neutral, unbiased, unprejudiced, or even truthful: and who would deny the unfortunate plaintiff the right to fight fire with fire and obtain the services of his expert, even though it is understood that his services may not be paid for unless, as a result of a favorable verdict, funds are made available for that purpose? No one would have you believe that medical experts will willingly commit perjury to benefit a client—at least, not often. In their zeal to be of assistance in the winning of a case and to sustain their expressed opinions, they may be forced to withhold information that would weaken their position.

Too many of us have known of instances where experts, when under the fire of belligerent and highly skilled cross-examination, are obliged to parry a thrust that was intended to penetrate the armor with which our present court system forces them to protect themselves as a matter of self-defense.

Too frequently attorneys feel that their well-prepared case is being undermined by adverse testimony, and will resort to methods of attack on a witness that he recognizes as a deliberate effort to impugn his motives and raise a doubt as to his honesty and capability.

THE SITUATION WHEN PHYSICIAN IS PLACED BETWEEN OPPOSING COUNSEL

In a "battle of wits" between opposing counsel and an expert, the attorney is battling over familiar ground—is schooled in the "art of cross-examination" intended to confuse and confound. Forcing his witness to give a "Yes" or "No" answer to a question may be in conformity with ethical

practices in court, while under other circumstances it would be looked upon as a "foul blow aimed below the belt."

Neither lawyers nor doctors can ignore the challenge that such a situation creates.

COURTS NEED AND SHOULD DEMAND UNPREJUDICED EXPERT MEDICAL OPINION

If justice is to be established, our judges should be given the authority, and such authority should be exercised so to conduct the trial of a case that intelligent, capable, unbiased, unprejudiced, non-partisan expert opinion can be placed before him and the jury.

Such opinions should come in response to questions submitted by the court. If they are irrelevant and immaterial, let the attorneys for both parties object, but let the force and effect of these objections result in nothing other than a contribution to delay.

The members of the medical profession have too meekly endured the ridicule that has been directed at them because of their willingness to assist counsel as witness to help him prove his case.

Neither judge nor gentlemen of the jury are capable of determining whether or not the expert is telling "the truth, the whole truth and nothing but the truth, so help me God"; so that if the truth were told they would not be able to recognize it as such.

In fact, opposing counsel too frequently place every legal obstacle at their command in the way of experts to prevent them from telling any of the truth that will seriously damage their case.

PRESENT LEGAL PROCEDURES PREJUDICIAL TO UNBIASED EXPERT MEDICAL OPINION

The court, the jury, the public know that this is true. It is for the purpose of focusing attention on this subject that this paper is being offered.

How refreshing it would be if medical experts were permitted to talk unhampered and unvexed by lawyers' objections, and in an atmosphere of freedom so that the truth would be permitted to emerge.

Is it not reasonable to suggest that the medical expert should be so chosen as to insure intelligent, scientific opinion being brought to bear on the case that is before the court?

Is it too much to ask that the doctor who serves as a medical expert should be looked upon as an honorable member of a dignified profession and entitled to be treated as such?

Are we justified in adding our protest and joining with those other protestants who insist that an expert is entitled to every consideration and demand that he receive it at the hands of both court and counsel?

No claim to originality can properly be made for any suggestions offered here: however, anyone should feel justified in making the observation that perhaps the present system of taking an expert's testimony no longer adequately serves the purpose for which it was established.

EARLY EFFORTS OF CALIFORNIA TO REMEDY COURT PROCEDURES

California was the first state in the Union to pass a law that was intended to overcome some of the objections which were so commonly offered to the usual court procedure. It provides that the court, upon motion of either plaintiff or defendant, may appoint an expert to make the necessary investigations and testify at the trial. It further provides that the court may appoint such an expert on his own initiative.

This law was enacted in 1925 as Section 1871 of the Code of Civil Procedure.

In 1909 Dr. Andrew Stuart Lobingier succeeded in bringing about the adoption of a resolution by the Los Angeles County Medical Association, calling for the appointment of a committee on "expert medical testimony." This committee was to confer with a similar committee of the Los Angeles Bar Association. The two committees, working jointly, were to prepare an act relating to expert testimony to be submitted to the legislature.

It was believed by the members of this joint committee that a bill could be drawn which, if adopted, would lead to the correction of some of the evils that had crept into the usual practice before the courts in connection with the presentation of expert testimony.

It was hoped that their suggested changes would restore the value of the services of the expert, eliminate the disgraceful spectacle of highly conflicting, partisan testimony coming from honored members of the professions, and permit both judge and jury to have unbiased opinions from experts of unquestioned ability. These opinions were to be given full consideration in arriving at a decision.

If time would permit, it would be very interesting to review the history of the efforts of Doctor Lobingier and his associates, which extended over a period of sixteen years. In passing, it should be stated that without the enthusiastic help and support of Mr. Oscar Mueller, representing the Los Angeles Bar Association, Mr. A. H. Koebig, representing the Society of Engineers, Judge Frank Oster, Dr. Thomas J. Orbison, and Senator Jones of San Jose, who gave sympathetic and valuable assistance, this legislation in all probability would not have passed even at the time that it did.

The first draft of a bill was prepared and submitted in 1911. It was rejected by the legislature at that time and a new and similar bill was introduced in 1913, which attracted more attention, but was rejected by the Assembly. In 1915 the bill passed both houses of the legislature, but was vetoed by Governor Johnson. In 1917 and 1919 the measure did not come up for consideration, but in 1921 it passed both houses of the legislature and was vetoed by Governor Stephens. It was finally passed in 1925.

Too much credit cannot be given to Dr. Lobingier, Mr. Oscar Mueller and their associates for the success of this long drawn-out, hard-fought battle, which ultimately resulted in a splendid vic-

tory. Additional credit should be given to these gentlemen because of the many years while they were giving of their time and efforts they also were called upon to finance themselves.

The proponents of Section 1871 felt that under its provisions the major difficulties encountered by the courts in obtaining dependable expert testimony needed for the proper and impartial administration of justice had been overcome.

ADDITIONAL CHANGES NEEDED

While definite improvement is evident, there still remains ample opportunity to go further and bring additional value of expert testimony to the court and forever destroy any grounds that the critic may stand upon when he refers to this form of testimony as a "racket," and those who are employed to offer it as "racketeers."

It not infrequently happens that a plaintiff's attorney, because of the insufficient finances of his client, is obliged to take his case on the basis of a contingent fee. If medical expert testimony is to become available to him, it also must be obtained on a contingent basis.

EXPERT MEDICAL TESTIMONY FOR THE PLAINTIFF

Ethically, perhaps, this is not right, but if there is to be even any semblance of equality before the law the plaintiff who needs help must be in a position to obtain it on any basis that is not illegal. If such expert testimony reveals that it is decidedly partisan, that it is colored and biased and, in the effort to be of assistance, the expert reflects his personal relationship with the injured, he can at least defend his action by the thought that he had a worthy motive. He wanted to help his fellow man who needed it, and if they won their case he was not averse to a little contribution to his pocketbook.

Incidentally, he may feel that to collect his fee his testimony must be convincing—the disability must be established and he must do his part in assisting the jury to determine the measure of damage to be awarded.

EXPERT MEDICAL TESTIMONY FOR THE DEFENSE

A defense medical expert, on the other hand, is in relatively the same position as that of the plaintiff. He also is receiving a fee. He is there to minimize the extent of injury, reduce the amount of award and, if possible, make a permanent disability appear to be only temporary.

Not infrequently, thinly disguised perjury has all of the force and effect of the wholesome truth. At this point, may we ask which of the motivating forces that control human conduct is the more effective, the hope for reward or the fear of punishment?

The expert witness of limited ability may direct his efforts too enthusiastically toward obtaining a satisfactory verdict for the plaintiff because of his hope for financial reward.

The expert witness for a defendant may be guided in his efforts and approach his task with equal enthusiasm, knowing that failure to be impressive and convincing may be a bar to his future employment for a similar purpose.

DIFFICULT POSITIONS OF BOTH SIDES

Such are difficulties of the scrupulously honest expert, who finds his testimony must be injurious to the interest of his employer, that he feels the delicacy of his position. He wishes that he might be permitted to escape. Carefully prepared apologies—though offered in profusion—seldom save his face. Subtle coercion not infrequently puts him on the right track before it is too late. He may even be recalled to correct his mistakes and partially overcome the effect of his damaging admissions.

Insurance companies, because of the frequency with which they are confronted with dishonest efforts to recover damages, are constantly on the defensive, and if they would succeed in preventing excessive awards, or the payment of claims for which there was no liability, their methods must be made to meet the practices which have grown up under our present court system.

Judges of the court, with possibly a rare exception, can be said to be honestly endeavoring to measure up to their responsibilities. There are those who know more, who have a better understanding, who are better informed medically as well as legally, and who conduct a trial more satisfactorily for all parties concerned.

In the light of what is known as to the existence of such conditions as we have enumerated, it is apparent that there is need for the more general use of medical experts on the basis provided for in Section 1871.

QUALIFICATIONS OF A MEDICAL EXPERT

But before leaving this subject, we might for a moment consider *who is an expert?* What qualifications are necessary to segregate a member of the professions from the ranks of those merely licensed to practice and exalt him to the position which places him among those recognized as *experts?* Such a question should not be answered by generalization. It requires that we should be specific and take into consideration all of the circumstances surrounding a given case.

For the purpose of our discussion, however, it may be safe to lay down certain rules which, if followed, would generally lead us to the individual whom we are seeking. We are referring now to the selection of a medical expert.

It must be obvious even to the uninitiated that an expert cannot hope to cover the whole field in which his profession operates. He is not able to qualify as an expert in every part or branch of that field. He who presumes to hold himself out as a specialist on "the skin and its contents" exposes himself to the possible discovery, in spite of his protestations of innocence that he is an impostor.

Present court practices are designed to provide plenty of embarrassment and many unpleasant moments for the expert of this type.

In this respect, members of the medical profession have been guilty of attempting "to take in too much territory," and have unwittingly offered themselves in an unfamiliar environment for the slaughter. Attorneys under such circumstances are willing to accommodate such an individual if they feel that they are adequately prepared. The scene adds color to the play.

He should expect no sympathy if, in the agony of his embarrassment, he wriggles and squirms and looks helplessly to the court for assistance.

The medically unqualified psychiatric expert should not be chagrined if during the ordeal of examination the spectators confuse him with the victim of delusions and hallucinations.

Egotism may be a normal attribute of man, but egomania we know to be a manifestation of a disordered brain.

One who is not an expert, but permits himself to be legally qualified as such, should move cautiously. Our medical associations have established a fairly satisfactory yardstick which can be applied to measure the qualifications of an expert. If a responsible group of fellow practitioners are willing to certify to the courts that a physician is a capable expert in a certain field, the litigants need have no fear that their interests will not be safeguarded, or that the witness lacks the necessary qualifications to meet the demands of justice.

The national movements for certification of experts in the various branches of medicine and surgery should prove to be most helpful to the courts—if the standards are sound and the certificates are issued only to those qualified to receive them.

Conflicting opinions have been so freely expressed by prominent judges and practicing attorneys as to what should be done to correct the existing unsatisfactory use of expert medical testimony in the California courts, that we perhaps should hesitate to offer any suggestions or recommendations.

IN CONCLUSION

In the face of all of these conflicting ideas, the following are our concluding observations:

1. Expert medical testimony in California, except as presented by a court expert, is a purchasable commodity and subject to all the distortion and mental obliquity which such a system makes possible.

2. Section 1871 of the Civil Code is capable of correcting, to an appreciable degree, the altogether too often abused privileges which the partisan expert witness finds open to him.

3. The efficient functioning of Section 1871 is in direct proportion to the finesse of the judges in their selection of honest, impartial and capable medical court witnesses, and in assisting and making possible the proper presentation of their testimony.

4. Section 1871 is worthy of much wider usage in the State of California, and would go a long way to eradicate the ridicule and often contempt which the false position of the medical expert allied with either litigant often brings upon himself and his profession.

5. A more thorough and impartial application of medical science to the needs of law deserves a much greater effort on the part of the two learned professions.

The writers make no professions of profundity in this paper. It is hoped the discussion will provide food for thought.

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DISCUSSION

ANDREW S. LOBINGIER, M. D. (307 West Eighth Street, Los Angeles).—This review of the subject of giving expert medical testimony in the courts of California is a comprehensive detail of the efforts some of us have put forth over a period of many years to establish, through legislation, a dignified and competent method of so presenting such evidence.

The Act (1871), which now is in force, authorizes the court to appoint its own expert when testimony for the plaintiff and defendant is so conflicting as to justify an unprejudiced expert opinion.

The interest in this subject reached an acute stage during the Thaw trial. The Los Angeles Bar Association requested me to discuss the subject of medical expert evidence at a dinner given in honor of the California Supreme Court judges about that time. The history of this development was later published, with a copy of the Act, in the *Journal of the California State Medical Society*.

Mr. Henry Taft, brother of President Taft, of the firm of Cadwallader & Taft, New York, became quite interested in the Act, and wrote me for a copy, as at that time he was moving to have similar legislation passed in the State of New York. California was the first state to pass such legislation, although it was undertaken without good results in many other states in the Union. Recently a bill has been framed to be presented for passage in New York, which is receiving favorable consideration.

It is quite impossible in this brief discussion to consider the many issues which came before us, most of which were discarded as impracticable. Weeks and months of conferences were held before the present form of Act 1871 was adopted. Then it had to be threshed out in the Committee on New Legislation for other protracted periods.

All this tedious and laborious effort is known only to those actively engaged in the long period of sixteen years, wherein these discussions took place. The gentlemen who have so well presented the history of this legislation could not be expected to consider the numberless forms the bill assumed before the succinct and practical text of the Act as passed was adopted.

We believed then and believe now that the Act governing the court's expert would not benefit by any addenda or amendment. We believe it is adequate to meet all requirements in the giving of an unbiased expert opinion whenever the aid of unprejudiced expert evidence is required.

The fact that it has not had a wider and more general employment in the courts in California is in no sense the fault of the Act, or the privilege it confers on the court; the fault lies entirely in the apathy of our judges in exercising their privilege.

Expert testimony has so long been discredited in our American courts, due largely to the incompetency of witnesses called to testify as experts, and to the persistence of the Bar in demanding that the expert they employ shall be favorable to their cause, that even with the Act in force, its practical application is constantly thwarted.

I know of only one way we can improve this lamentable situation, and that is for the medical profession to definitely decline to appear in court to give expert testimony, except as the court's witness. For with this law in force the criticism that expert evidence is worthless and futile, so long charged by judges and lawyers, has quite lost its meaning in California.

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HUBERT T. MORROW, ESQ. (837 Van Nuys Building, Los Angeles).—The article by Doctors Barnard and Tucker on "Expert Medical Testimony in California Courts" leaves little to be said that would add any new thought. The writer, having been requested merely to discuss the article, will not assume to repeat any of the views expressed in that article or to bolster it with arguments supporting those advanced by the authors. It is quite patent to anyone with any experience of the subject that practically all of the observations of Doctors Barnard and Tucker are well founded.

The writer recalls the efforts over a period of many years by both the medical and legal professions to provide a statute that would correct the evils mentioned in the above article. Section 1871, Code of Civil Procedure, was the result of those efforts, and it represents the utmost then obtainable. That provision of the law has, in a general way, and to some extent, improved the situation, and in some particular cases it has operated to eliminate the evil of partisan expert medical testimony. However, I believe it is employed in a minority of cases, and even then generally where each side exercises its right under the statute to call its own experts.

The evils pointed out by the article under review could be wholly removed only by denying to any party the right to call his own experts, and by placing in the court's hands the power and duty of appointing qualified and disinterested expert witnesses who would be subject to cross-examination by each party to the litigation. Some such control of expert testimony would be in line with the thought and practice of some foreign jurisdictions, and is not an innovation in juridical thought. Centuries ago in England it was not uncommon for the courts to impanel a jury of matrons to advise the court concerning controverted facts involving pregnancy, and other illustrations might be given of early recognition of the value of independent expert testimony.

While the writer has on numerous occasions observed medical and other experts called by one party or the other, give most conscientious, fair, and honest opinions, such as they would have given if called by the court itself, nevertheless there are far too many instances where experts fall into a partisan attitude that makes them special pleaders for the side calling them. And, of course, in many cases one is confronted by the "professional," venal or incompetent expert witness, whose biased testimony often results in unjust determination of the issues.

The question which the expert is to answer is one upon which the court or jury requires guidance, because it is outside the ordinary experience of laymen. Necessarily the expert gives his opinion upon the subject, either from his own examination (stating the facts in that regard), or from an assumed state of facts recited to him in the form of an hypothetical question which, in turn, is based upon testimony as to facts pertinent to the case. The opinion of the expert should be fair, honest and unbiased, and he should be as far removed as possible from interest in the outcome, personal contact with either party or advocates of such party. Thus only can there be assured reasonable opportunity for fair and correct answer to the technical problem that confronts the court or jury, and which necessitates the calling of experts.

Some twenty-five years ago I had the pleasure of meeting that able man, George Franklin Shields, M. D., and had with him an evening's discussion of the problem in question. Some of the members of the medical profession will recall him. In the course of an address previously delivered by him on the subject of medical expert testimony, he said:

But, gentlemen, expert medical evidence could be made of the greatest value in forwarding justice were it properly introduced. May I suggest two perfectly feasible plans: (1) Let the attorneys of each side select two experts, and

let the four thus chosen agree on a fifth. These five men could, after careful deliberation, bring in a full and useful report on any technical points placed before them. Or (2) leave the matter entirely in the hands of the court, who could call one or a dozen medical men to elucidate, with absolute freedom from bias, any technical points which might arise in a trial. I incline strongly to favor the court having the control, since it would entirely do away with the possibility of partisanship, provided always that the court is what it should be—learned, dignified, and absolutely impersonal. Under this rule the very best men in the ranks of the medical profession would always be ready and glad to give their services, instead of shunning the courts on account of the false position in which they are so frequently placed by the warring attorneys.

In the year 1870 one of the ablest Supreme Court justices of this State, Justice Jackson Temple, said, in deciding a case then before the Supreme Court (40 Cal. at p. 405) :

These witnesses (experts) ought, perhaps, to be selected by the court, and should be impartial as well as learned and skillful. A contrary practice, however, is now probably too well established to allow the more salutary rule to be enforced, but it must be painfully evident to every practitioner that these witnesses are generally but adroit advocates of the theory upon which the party calling them relies, rather than impartial experts, upon whose superior judgment and learning the jury can safely rely. Even men of the highest character and integrity are apt to be prejudiced in favor of the party by whom they are employed.

The above excerpts indicate that the problem in this State has long been recognized by the professions and that there has been little change in the view that expert testimony should be removed from partisanship and elevated to the position where it really can assist in accomplishing justice to all parties.

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HARTLEY F. PEART, ESQ. (111 Sutter Street, San Francisco).—The paper entitled "Expert Medical Testimony in California Courts" concerns itself with a subject which is of great importance in the practical administration of justice in the trial courts of this state. While the paper is concerned with expert medical testimony only, the problems presented and the conclusions which are drawn are of great significance to many persons other than medical men. The paper may well be expected to provoke thought and discussion which will ultimately prove of benefit in the better administration of justice in this state.

The authors of the paper quite correctly illustrate the underlying defect in the method now used to introduce expert medical testimony before the trial courts of this state. Too often, under the practice in vogue, an expert witness cannot be considered as unbiased, impartial, and nonpartisan. While it is undoubtedly true that in a great many instances the expert witness is absolutely unbiased, impartial and nonpartisan, the fact remains that many experts who take the witness stand are not so considered by the jury, the judge or the attorneys in the case. The expert is looked upon as an advocate striving to protect the best interests of the person by whom he is paid. The legal justification for allowing a person to give his opinion in any lawsuit is that such a witness is, by virtue of his knowledge and skill, in a position to draw conclusions and state opinions concerning matters about which the jury would have no special information. Thus, an expert witness should be considered as a friend of the court who is willing to use his special skill and knowledge that justice may be obtained. Since an expert witness is in the great majority of cases now considered to be partisan for the reasons pointed out in the paper under discussion, it is understandable why the opposing counsel must use all the learning and skill at his command to discredit the testimony of the witness. As a result, many highly qualified and desirable experts decline to take the witness stand and undergo the physical and mental strain which is involved in defending their opinions.

A question which is of importance to every doctor is whether he may refuse to appear and testify as an expert unless he is paid more than the statutory witness fee. This problem has never been squarely passed upon by the

courts of this state. The problem was presented to the court in the case of

Webb vs. Lewald Coal Co., 214 Cal. 182.

The court decided the case upon other grounds and stated:

The troublesome question as to when it is proper in litigation between private parties to compel an expert witness to give his professional opinion without consent or compensation, though discussed by counsel and by *amici curiae*, does not freely arise on this record. Hence, it will not be here considered.

What little authority there is in this country in regard to this problem seems to favor a ruling that an expert may not be compelled to testify as to matters of opinion without receiving extra compensation therefor.

The broad problems considered by Doctors Bernard and Tucker have been weighed at some length by many writers, both in the State of California and throughout the United States. Hon. Arthur L. Mundo, Judge of the Superior Court, San Diego County, in the May, 1935, issue of the "State Bar Journal," in discussing the problem, takes as his premise the fact that the procedure under which expert testimony is offered in the trial courts is in need of reform. His suggested cure for the evil is to repose the power of appointing experts exclusively in the courts, thus making the expert witness an officer of the court. In order to make this plan feasible, Judge Mundo suggests that a panel of expert medical men and women in each county be submitted to and finally approved by a majority of the judges of the trial court. The county medical societies would certify these experts. When it became necessary for an expert to aid the court, the names of the experts in the field of medicine involved would be placed in a sealed box and drawn in the same manner as jurors are drawn. The litigants would have only the right to disqualify the expert chosen upon properly showing prejudice, bias or interest. In civil suits the cost of securing such expert testimony would be taxed upon the litigants, as the court should determine proper. In criminal cases the charge would be against the county.

Judge Mundo's proposed plan has been criticized by several members of the bar of this state. In general these criticisms are that the best medical experts would not be placed upon the panel, and that such a plan would add to the cost of a lawsuit, thus preventing many plaintiffs from securing justice. (See "State Bar Journal," July, 1935, p. 183.)

The authors of the paper under discussion are among the few writers upon this subject who recognize that California has a statutory law which, if properly carried out, would go a long way toward correcting the abuses of the method now commonly used to introduce expert testimony. Section 1871 of the Code of Civil Procedure provides, in substance, that the judge of a trial court may on his own motion, or on the motion of any party, appoint one or more experts to investigate and testify relative to the matter or matters as to which such expert evidence will be required. It is also provided in this section that the litigants may produce their own expert witnesses, and it is further provided that the judge may limit the number of experts to be called by any party. It is quite clear that this law is an attempt to take a middle ground. While it has not proved as efficacious as it might, it seems to this writer that with coöperation on the part of the county medical societies, along the lines suggested by Judge Mundo, with the judges of each Superior Court, the evils of our present system, in so far as expert medical evidence is concerned, would in a large degree disappear. Since this proposal involves no change in statutory law or in the theory of the proper function of an expert witness, it would seem that the proposal should be entitled to a trial.

The conclusions reached by Doctors Barnard and Tucker show that much careful thought and consideration have been given to this very troublesome problem. As this problem is essentially practical and not merely academic, the paper under discussion is entitled to the serious consideration and discussion of the members of the medical and legal professions. It is only in this manner that we may obtain a necessary reform in the administration of justice.

THE THYMUS IN HEALTH AND DISEASE*

By PAUL MICHAEL, M.D.
Oakland

DISCUSSION by Francis Scott Smyth, M.D., San Francisco; Howard L. Eder, M.D., Santa Barbara.

INCREASED attention to endocrin disorders in the last few years has stimulated our interest in the thymus. Experimental work on fish and mammals has, as yet, failed to establish the full significance of this gland's function. The scope of this paper includes an embryologic and physiologic discussion, with a report on the study of two hundred clinical case histories and their protocols.

EMBRYOLOGY

Although we know it originates from the ventral aspects of the third and fourth branchial clefts, the thymus anlage descends from the pharynx to lie in the lower neck and in the thorax over the base of the heart. Its origin establishes it as an epithelial organ, but the microscopic make-up is unmistakably lymphoid. Because of the embryologic association of the thymus and parathyroid glands, there is a certain structural and functional relationship: structural, in that parathyroid tissue may be found within the thymus; and functional in that both are associated in some way with calcium metabolism. The thymus is divided into two main parts—the neck thymus and the thoracic thymus. It has two lobes and is composed of cortex and medulla, all enveloped within a fibrous capsule. The adenoid tissue of the peripheral cortex is more closely packed than that in the medulla. The lobes are subdivided into lobules held together by an interlobular connective tissue. The smaller lobules, 5 to 10 millimeters in diameter, are further divided by septa into smaller compartments, each of which contains several secondary lobules. The secondary lobules are made up of many primary and secondary follicles resembling lymph follicles in structure.

Scattered through the gland are Hassall's corpuscles—large, round or ovoid bodies, which stain faintly and have irregularly concentric laminations. These bodies may have some endocrin importance, or may be products of degeneration; their origin and function, for the present, however, must still be left to conjecture. The blood vessels run in the interlobular connective tissue and give off branches which penetrate the follicles as a large capillary network. Accompanying this network is a very luxuriant lymphatic vascular tree.

FUNCTION

Research work on the function of the thymus gland is principally confined to animal experimentation. The history of the thymus problem is a laborious one, and will be summarized in brief.

Restelli,¹ in 1845, showed that the thymus was in some way connected with the rate of growth during early development. Friedleben,² in 1858,

likewise showed the significance of the gland in osseous development and believed it also to be of hematopoietic importance. Basch,³ in 1902, demonstrated again that the gland was concerned with growth and also the calcification of bone. Soli,⁴ in 1910, showed that thymectomy in chickens resulted in the laying of eggs without shells. Hewer,⁵ in 1914, continued the studies started by Basch and demonstrated the relationship of the thymus gland and calcium metabolism. Klose and Vogt,⁶ in 1914, removed the thymus in young animals and claimed this resulted in adiposity and cachexia, accompanied by spontaneous fractures. The painstaking work of Park and McClure,⁷ in 1919, set forth in their monograph on the thymus gland, threw the entire subject into turmoil by questioning most of the experimental work done up to that time. They felt that the thymus had little influence on the growth of the body or alteration of the hair and teeth. They admitted that there may be some slight retardation in development because of delayed calcification. The period 1919 to 1931 was the golden era of romance for the thymus gland. Numerous obscure conditions were credited to the thymus, and all unusual deaths were accounted for on this basis. Young and Turnbull,⁸ in 1931, attempted to refute this entire theory, and claimed that the thymus was in no way associated with sudden death. Although unable to explain the method, most American observers believe that status thymicolymphaticus is a condition *sui generis*, and not infrequently associated with otherwise unexplained fatalities.

Some of the most significant animal experimentation work has recently come from the Philadelphia Institute for Medical Research. Rowntree⁹ and associates, using an acid aqueous extract of the neck thymus of young calves called karkinolysin (Hanson,¹⁰ 0.6 gram of raw thymus per cubic centimeter), experimented on white rats obtained from the Wistar Institute. These rats were injected intraperitoneally daily for six months. In the first generation the animals were heavier, bred more frequently, and had larger litters of heavier rats. No definite changes occurred in the second generation in the first six litters, but in the seventh to the eleventh litters evidence of precocity occurred. In the third to the seventh generation, acceleration in the rate of growth and precocity were marked, and increased with each succeeding generation. Rowntree⁹ reported certain chemical changes which occurred in these animals. Thymus-treated rats, from the second to the fourth generation, showed an increase in serum calcium, ranging from 11.4 to 13.3 milligrams per cent, with an average of 12.3; and the inorganic phosphorus ranging from 4 to 7.5 milligrams per cent with an average of 6.1. The controls showed a serum calcium from 9 to 11 and the phosphorus from 3 to 4 milligrams per cent. There was no deviation in the blood count. X-ray studies showed increase in the size of the bones, with earlier appearance and calcification of the ossification centers. Thymus extract in small doses showed no reaction on the heart, but large amounts resulted in shock, fall

* Read before the Pathology and Bacteriology Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25 to 28, 1936.

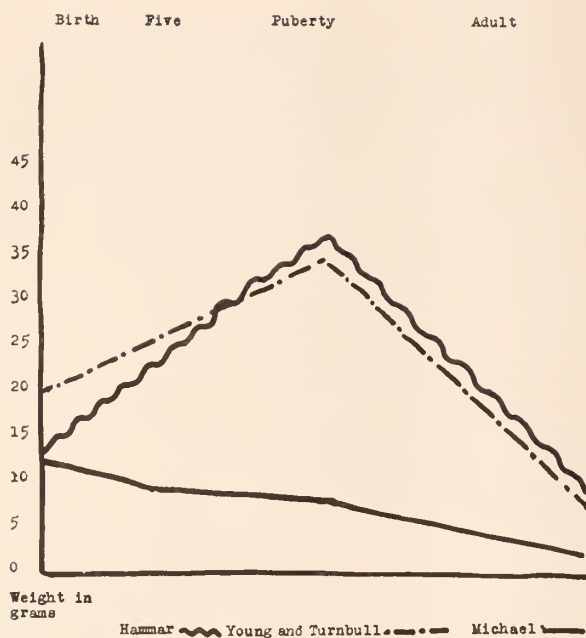


Chart 1.—Comparative weights of thymus

in blood pressure, and auriculoventricular heart-block. All these results were obtained by using the old thymus extract prepared by Hanson in 1930. Fresh extracts showed very little stimulation, and oral administration was ineffective.

CLINICAL APPLICATION

The clinical conception of this problem is even more confused than the experimental. The unfortunate weakness is that most experimental findings are not borne out in their clinical application. It is natural, then, that much incorrect pathologic significance has been given to the thymus gland, partly because we have failed to establish the normal. It appears that the thymus is enlarged in Graves's disease, Addison's disease, acromegaly, status lymphaticus, sometimes in rickets, asthma,¹¹ and most often in myasthenia gravis. The thymus may be enlarged in eunuchs, and its involution is delayed in early castrates. It normally involutes after puberty, probably inversely as the development of the reproductive organs takes place. It was thought by the older writers to diminish in size in starvation, inanition, and general wasting diseases, and to enlarge in certain acute diseases in children or young adults.

MATERIAL FOR THIS STUDY

It was upon these last questionable tenets that work was originally instituted as to qualitative and quantitative changes in the thymus gland, and the development of a normal weight curve. The glands were completely removed, weighed, studied grossly and microscopically, and correlated with the clinical findings. Six cases of lymphoblastoma and eight cases of apparent status thymicolymphaticus were eliminated from the study, some of these latter having been reported in a previous communication.¹² The study includes two hundred cases, of which one hundred were children

under fifteen years. Friedleben,² Kasarinow,¹³ Von Sury,¹⁴ Hammar,¹⁵ Ronconi,¹⁶ Klose,¹⁷ Bratton,¹⁸ Scammon,¹⁹ and Boyd,²⁰ all agree as to the average birth weight—9 to 14 grams. The majority of the investigators reported much higher puberty rise and prepuberty rise than my series, while Young and Turnbull⁸ and Hammar¹⁵ reported weights in adults far in excess of those seen in the present series.

Time does not permit a complete correlation of the clinical and autopsy protocols established in these two hundred cases. A summary of the findings, however, includes the following points: The average birth weight was 12 grams. There was then a steady decline to the age of five years, when the average weight was 10 grams. From then on to puberty the decline was more gradual, with the average weight being at this time 9 grams, establishing almost a continuous horizontal line. From puberty on to adult life, however, there was another drop. The average weight in adults was 2.5 grams. The thymus in males, on the average, was slightly heavier than that in females, although the difference was not always appreciable. There was no correlation between acute infectious diseases and enlarged thymus. It appeared that the enlarged thymus in certain diseases, such as diphtheria, fulminating septicemia, etc., was part of an inherent constitutional state of the individual, contributing to the disease rather than the result of it, indicating a low resistance or lack of immunity. Evidence favored the fact that an enlarged thymus gland was probably a primary enlargement rather than a secondary one, resulting from toxemia. As acute, subacute, and prolonged wasting diseases were included in this study, no definite correlation was seen between the latter conditions and atrophic thymus. As a matter of fact, this group conformed to the normal established by the series. There is no satisfactory explanation forthcoming accounting for the discrepancy between my figures and those reported in other series. Complete extirpation was done and accurate weighing was maintained throughout.

No study of the thymus gland is complete without at least mentioning the condition called lymphatism, or status thymicolymphaticus. Probably one of the most controversial, certainly one of the least understood, it remains one of the most frequently mentioned conditions. Lymphatism is a state in childhood, or occasionally in adults, when lymphoid tissue, normally present in but small amounts, is found to be flourishing and luxuriant. Not only is the thymus itself larger than normal, but the lymphatic tissue generally is hyperplastic—especially in the lymphoid follicles in the mesentery and along the gastro-intestinal tract. The body may be characteristically thin and undeveloped, or may show an unhealthy, pale, flabby overgrowth. There is usually a small heart, small blood vessels, frequently with defective walls, and hypoplasia of the adrenals. There may be a marked allergic tendency¹¹ or some exudative diathesis. Unexplained death even from trivial causes may occur, and attempts at explanation may bring to

mind the possibility of an exudative diathesis, an overwhelming toxemia from excessive lymphoid breakdown²¹ or fatal heart-block from excessive calcemia.⁹

SUMMARY AND CONCLUSIONS

1. The thymus gland is reviewed embryologically, physiologically, experimentally, and clinically.

2. A brief review of the literature is included.

3. Two hundred case histories are summarized in which the thymus was studied. Birth weights agreed with those reported by other observers, but puberty weights and adult weights were much less than those generally given. There was no definite relationship existing between enlargement of the thymus and infection, or atrophy of the thymus and wasting diseases.

4. A résumé of status thymicolymphaticus is given, and the claim that it is a condition *sui generis* sustained.

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DISCUSSION

FRANCIS SCOTT SMYTH, M. D. (University of California Hospital, San Francisco).—The subject of Dr. Michael's paper is one which will precipitate considerable argument in any medical group. The older orthodox viewpoint, that the thymus enlargement is in itself responsible for certain sudden deaths, has been in some instances a smoke screen to hide our ignorance. In the first place, post-mortem examinations of sudden deaths in healthy children before puberty should show normal healthy tissues in contrast with those examinations after wasting illnesses. While Doctor Michael's study shows that thymus hypertrophy is still independent of such conditions, the studies of Boyd would tend to show a distinct difference in the thymus of a healthy child and that of a sick one.

A number of years ago Dr. O. M. Schloss had his house staff correlate x-ray diagnosis and pathologic measurements of the thymus. While our series was small, we were convinced that there was frequently a false interpretation of x-rays, as judged by the actual size of the thymus.

More recently Waldbott and others have collected evidence which strongly suggests that anaphylactic-like episodes may be concerned with some of the instances reported as thymic deaths.

It is well, then, not to overlook other causes, such as cocain shock, anaphylaxis, etc. On the other hand, despite the discrepancy between the x-ray and the postmortem findings, it is probably safer to resort to x-ray therapy, when careful x-ray suggests thymic enlargement, than to philosophize on the inadequacies of medical methods.

Unquestionably, from studies such as Rowntree is making, we will find the nature and place of the thymic hormone in the present maze of endocrines. Mention should be made of the clinical observation of symptoms similar to thyrotoxicosis apparently associated with thymic hyperplasia and responding to thymic extirpation. Mention should also be made of the frequency with which aberrant parathyroid tissue may be found in the thymus gland.

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HOWARD L. EDER, M. D. (1421 State Street, Santa Barbara).—Doctor Michael has given us a very complete, interesting and illuminating article on the thymus gland. Many articles relating to this rather small gland published during the past twenty years have caused considerable confusion in the minds of not only the doctors, but also the lay public. Recent articles have helped to straighten out some of the confusion in the minds of the doctors. No doubt, in the near future we will know enough about this small gland and other ductless glands to aid us materially in the diagnosis and treatment of certain diseases.

I am sure that in pediatrics a syndrome complex is encountered which, whether it is caused by the thymus gland or not, at least responds to x-ray therapy over that region. These cases present a rather typical picture, consisting usually of vomiting, sinking spells with cyanosis, colic, and irritability. These babies cause great concern to the mothers, and when undiagnosed do very poorly. During an attack the simplest procedure is to hold the baby head-down until the cyanosis disappears.

The x-ray picture generally shows an enlargement of the thymus gland, not only in breadth but also in unusual thickness. Auscultation in this region will usually give diminished heart sounds and there is a dullness on percussion. X-ray therapy has always relieved the symptoms of this peculiar condition in the cases I have observed.

The lay public is very much concerned about the enlargement of the thymus. Parents frequently ask to have a new-born baby x-rayed for possible enlargement of the thymus. They also ask frequently to have the thymus x-rayed before an anesthetic, particularly for the removal of tonsils.

So many articles have been published on status thymicolymphaticus in the past that it is impossible to convince patients that this condition is probably coincidental with sudden deaths. It will take a long time to convince the public that the thymus is of great importance in growth and development, but probably plays little part in disease.

MISSED ABORTION *

By J. MORRIS SLEMONS, M.D.
Los Angeles

DISCUSSION by C. Frederic Fluhmann, M. D., San Francisco; Frank W. Lynch, M. D., San Francisco; Norman H. Williams, M. D., Los Angeles.

THE belief has become traditional that a vigorous reaction on the part of the uterus will promptly expel the product of conception whenever the fetus dies. As a rule, it happens so; and yet an interval of six weeks often passes before the abortion occurs. Should the delay be longer—several months, rarely a year or more—many vexing questions will arise; some theoretical, others quite practical in their implications. At times the interwoven medical and social features assume a legal aspect, and may provoke a lawsuit. The best known illustration of this contingency relates to a distinguished British gynecologist, a generation ago, who failed to consider all the possibilities in the case of a prominent London woman whose husband had been absent in India a year when she aborted a disintegrating ovum which presented an early stage of development. That the husband could not be responsible for the pregnancy was the opinion the gynecologist expressed; and in the courts he lost a suit brought against him for defamation of character. In fact, the prolonged retention of a dead embryo created this embarrassing domestic situation. Missed abortion was the correct diagnosis.

FREQUENCY

Missed abortion of impressive duration was once thought to be an extraordinary complication. Now, we know, it occurs much more often than intimated by the report of E. Fraenkel,¹ in 1903, who was able to collect only 105 cases, including his own. Current textbooks reflecting the personal experience of their authors agree that its incidence has been underestimated. Thus, Taussig,² in a comprehensive monograph just published, says that one-tenth of all the abortions in his own practice were retained a sufficient length of time to permit classification as "the missed" variety.

This complication is treated somewhat more frequently in private practice than in institutions which serve the poor. Malnutrition, fatigue, jolts and jars, hard work of all kinds, favor abortion whether the fetus is alive or dead. Among the well-to-do, on the other hand, when premonitory symptoms develop, treatment becomes insistent and often succeeds in abating a stimulus that otherwise would set in motion the expulsive muscular mechanism. The elimination of exercise, enforced rest to the point of keeping a patient in bed, and the abundant administration of sedatives, all assist toward defeating nature in her purpose to rid the woman of a fruitless pregnancy. And so, paradoxically, modern precautionary measures which safeguard the prospective mother increase the incidence of missed abortion.

REPORT OF CASES

CASE 1.—Age, 23. Gravida 1. Last menstrual period began September 13, 1930. Normal progress for four months; never felt fetal movements. January 5, 1931, fundus nine centimeters above symphysis. January 14, abdominal pain of moderate intensity, one day; no bleeding. January 21, uterus the same size as one month ago. February 18, uterus smaller than at last visit and cannot be felt abdominally; on vaginal examination, found a retroverted uterus about the size characteristic at third month of pregnancy. General health excellent. When told of possibility of missed abortion, the patient insisted nothing was wrong.

Operation.—February 27. Dilatation of cervix and removal of ovum with placental forceps; curettement.

Pathologic Report.—Fragments of placenta. Fetus nine centimeters long; tissues dry and tough (mummification). Microscopic study shows shrunken chorionic villi. Endometrium regenerating: stroma cells small, glands resemble those of nonpregnant uterus rather than of decidua. Estimated retention period of dead fetus was three months.

1 1 1

CASE 2.—Age, 43. Gravida 10. Eight living children; miscarriage at three months in 1922. L. M. P., January 5, 1927. Mild attack of influenza in February. X-ray treatments for pruritus vulvae during March and April. Slight vaginal bleeding for two days early in May and again on May 26; no cramps or backache. On June 11 she arrived in Los Angeles after a transcontinental railway journey, and shortly after reaching the hotel she noticed vaginal bleeding. The husband, a physician, thought pregnancy out of the question. The uterus, asymmetrically enlarged, corresponded in size with the third month of gestation. A round mass within the uterus at the right cornu, four centimeters in diameter, was interpreted as a myoma.

Operation.—June 14. Dilatation of cervix; digital exploration of uterine cavity. The mass just mentioned proved to be an hematoma mole. Contents of the uterus removed with placenta forceps; cavity packed with gauze. Bleeding scant until pack was removed after being in place twenty-four hours. Subsequently, excessive lochia for ten days, when uterine cavity was explored and no placental fragments found. At husband's request, radiation was employed and bleeding ceased. Recovery.

Pathologic Report.—Placenta penetrated by and covered with old blood-clots (Breus mole). In the center of the mass was a macerated embryo 3.5 centimeters long. Estimated retention period was four months.

1 1 1

CASE 3.—Age, 35. Gravida 2. One living child delivered by low forceps on account of maternal toxemia (albuminuria). L. M. P., February 16, 1931. No ailments in early months. June 12, fundus eight centimeters above symphysis. July 13, no quickening; uterus the same size as a month ago; slight cramps and "spotting." On August 13 the hormonal urine test (Friedman) was negative.

Operation.—August 15. Dilatation of cervix and removal of uterine contents with placental forceps.

Pathologic Report.—Fetal sac intact, containing macerated embryo nine centimeters long. Estimated retention period was three months.

1 1 1

CASE 4.—Age, 32. Gravida 3.—Two illegal abortions. L. M. P., May 15, 1930. When first seen, July 20, the uterus was enlarged and soft, but could not be outlined clearly on account of chronic inflammatory adnexal disease. The hormonal urine test (Friedman) was negative. July 31, severe abdominal cramps and moderate uterine bleeding.

Operation.—July 31. Dilatation of cervix; removal of uterine contents with placental forceps.

Pathologic Report.—Fetal sac intact, containing an amorphous lenticular mass, the embryo, one centimeter long, five millimeters thick. Estimated retention period was six weeks.

* Read before the Obstetrics and Gynecology Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

CASE 5.—Age, 23. Gravida 1. L. M. P., July 15, 1932. Her physician, consulted September 28, made a diagnosis of pregnancy. Quickening was never felt. No ailments. On February 3, 1933, as the abdomen failed to enlarge, the physician doubted the correctness of his primary diagnosis and was confused, especially by a negative hormonal urine test (Aschheim-Zondek). Then I saw the patient in consultation, and found the uterus approximately twice normal size; otherwise nothing noteworthy. Suspecting a missed abortion, dilatation and curettement were recommended. This was done by her physician, who reported the removal of placental tissue. Estimated retention period was six months.

CLASSIFICATION

How long must the dead fetus be retained before the diagnosis of missed abortion is warranted? Heretofore, attempts at definition, somewhat arbitrarily, were based upon a comparison of the developmental age of the embryo with the menstrual age of the pregnancy. Guided in that way, clinicians regarded a retention period of six weeks as requisite to correct classification. All the cases of this series fulfill that requirement: an interval of from six weeks to six months elapsed between the death of the fetus and the termination of pregnancy by instrumental means.

In the past no reasonable objection could be raised against the "time criterion"; but now, having at hand the hormonal urine test, it seems preferable to differentiate cases on that basis. In other words, the diagnosis of missed abortion, in my judgment, should be made only after the Aschheim-Zondek or Friedman reaction has become negative. Of course, it does not become so immediately after the fetus dies. As long as vitalized placental tissue remains, the test will be positive; until it becomes negative we must consider the possibility that the uterus will empty itself spontaneously. This suggestion, however, applies merely to the first half of pregnancy, the period corresponding with the accepted use of the term "abortion"; nearer term, Wilson and Corner³ find that a positive hormonal urine reaction persists far too long after fetal death to serve the practical purposes of diagnosis and treatment.

The hormonal urine test was negative in three of my cases. Although not employed in the other two, they were correctly classified; the uterus of one of them contained a hematoma mole, the other a mummified fetus.

CLINICAL MANIFESTATIONS

In contrast with the frank, troublesome manifestations of most bodily derangements, the maternal symptoms of fetal death are conspicuous for their negative character. Breast engorgement vanishes, nausea and vomiting cease. A good appetite replaces a distaste for food. The tendency to lose weight is arrested; often the patient begins to gain, gradually and moderately. Relieved of the distinctive ailments of the early months, the prospective mother assumes everything is going as it should.

Invalidism in these cases, which impressed Litzenberg,⁴ must be extraordinary. None of my patients complained of a foul taste, an offensive leukorrhea, chilly feelings, or malaise; neither were they profoundly anemic, feverish in the

afternoon, or mentally disturbed. That infection seldom occurs is a remarkable fact, probably explained by organic readjustment to the changed embryologic situation. The muscular wall of the uterus becomes firmly retracted, its blood vessels undergo alterations which narrow the lumen and the endometrium begins to regenerate. None the less, precaution must be unremitting against the introduction of contaminating material; vaginal examinations, limited in number, will be made with strict aseptic technique and the marital relation forbidden.

A pregnant uterus of stationary or diminishing size provides the most significant clinical evidence of fetal death. At first the patient fails to notice that her abdomen is not growing larger; and, if she has not yet reached the time for quickening, this sign, or its absence, cannot be utilized. On clinical grounds the physician forms an opinion, beyond cavil, only after reexamination of the patient at the end of a month. Meanwhile, if the laboratory reports a negative hormonal urine reaction, the debate is closed.

As a rule, very slight symptoms of threatened abortion follow directly upon fetal death, symptoms often insignificant to a patient accustomed to much more severe cramps with menstruation and indifferent to a faint discharge of blood. Should she communicate with her physician, he will recommend sedatives and continuous rest in bed. Typically these measures soon afford relief, and she resumes her customary routine for a longer or shorter interval until outspoken signs of abortion appear, or clear proof of fetal death warrants surgical treatment.

Neglected cases, women who first seek medical advice long after the fetus has perished, formerly presented great diagnostic difficulties. It was not easy to decide whether or not the uterus contained a pregnancy; and, if so, was the embryo alive? In these circumstances modern methods become most helpful, especially the hormonal urine test. A positive result impels delay; a negative one at least permits active treatment without the hazard of ending a pregnancy unwittingly. Even today, however, the differentiation of missed abortion and myoma can be perplexing, as I once had occasion to learn. Upon arrival from the East the patient began to bleed shortly after reaching a hotel and was brought to the hospital by her husband, a physician, who thought pregnancy out of the question. The history and the pelvic examination were in harmony with the diagnosis of myoma, but at operation a hematoma mole was found.

Clinical study seldom, if ever, discloses the cause for retention of the fetus. Consequently, in the case just mentioned it is noteworthy that repeated radiation had been used for the treatment of pruritus vulvae. In another case pelvic inflammatory disease had persisted since a former pregnancy was aborted illegally. There the chronic pathologic lesions, which included metritis, are suspected as responsible for uterine inertia. Isolated cases, to be sure, even correctly interpreted,

fail to indicate the broad principles which underlie prolonged retention of the fetus. For these we must look further.

PATHOLOGY

Anatomic research has taught a great deal with respect to the structural changes which precede and accompany the immature arrest of embryologic development. With a rich material, contributed by midwives as well as physicians, Mall⁵ demonstrated in abortions that the primary defect of the gestational organization centers around the nutrition of the embryo, and that it dies before the placenta loses its vitality. Primarily, the maternal tissues are often at fault, but not always; the protoplasm of the embryo may be defective. Less intense grades of malnutrition, not severe enough to cause death, interfere with perfect embryonic development. These focal imperfections, in particular intra-uterine amputations, have been studied by Streeter.⁶

When the embryo dies, it becomes a foreign body—a permissible description for want of more exact information—and nature endeavors to cast it off. To this rule there are a few exceptions. A. W. Meyer⁷ found that resorption of a conceptus occurs in women just as in multiparous mammals. He learned, too, that the embryo vanishes before the structures which protect it. This eventuality, of course, will be impossible unless development has ceased at an extremely early stage. Later the bulk and composition of the ovum prevent complete dissolution and absorption; it must then be removed by way of the birth canal. Presumably the uterus always tries to accomplish that result and occasionally fails because its contractions are either too infrequent or too weak.

Seeking the underlying cause of uterine inertia, it is not difficult to choose the path to follow. Let us see what help has already been had from endocrinal research. Of this there have been two pertinent varieties: one relates to the corpus luteum hormone, progesterone; the other to estrin, a hormone of great importance in fitting the uterus for parturition.

HORMONAL CONTROL

Snyder⁸ demonstrated in the case of rabbits that the intravenous injection of urine from a pregnant woman postponed the birth of their young, and he attributed their retention in the uterus to the action of hormones. His conclusions were based upon a brilliantly conducted research the steps of which may be very briefly recapitulated. A small amount of chorionic gonadotrophic (anterior-pituitary-like) hormone thrown into the maternal circulation induced spurious ovulation, although the rabbits were already pregnant. The ovarian follicles which responded to this stimulus underwent the customary transformation into corpora lutea. Accordingly, parturition did not occur upon the ordinary date (thirty-two days postcoitus), but was deferred until the induced corpora completed their life cycle, postponing the delivery until the fortieth day, and prolonging pregnancy by a period 25 per cent of its usual duration. Specifically, the delay was due to the

artificial production of corpora lutea and the consequent influence of their hormone. Snyder argues convincingly that the rabbit's uterine musculature remains quiescent during pregnancy in response to progesterone. Does the same reasoning apply to women? Probably so. At least this inference has the support of collateral evidence from other sources.

In 1903, L. Fraenkel⁹ observed that women aborted when the corpus luteum was ablated in early pregnancy, or the ovary containing it removed. In other words, as it now appears, the depletion of progesterone permits the establishment of efficient uterine contractions. More recently, Corner and Allen¹⁰ have shown that the corpus luteum functions in this way, among others. Clinical application of their work, reported by Falls, Lackner, and Krohn,¹¹ emphasizes the inhibitory effect of progesterone upon cases of habitual and threatened abortion.

It is significant, as Streeter remarks, that the expulsion of a conceptus is retarded conspicuously when fetal death occurs between the sixth and the seventeenth week of development. At this period the corpus luteum is relatively large; the placenta small; the amniotic fluid less abundant than later. Each of these environmental factors must be taken into account before the explanation for missed abortion becomes full and final: the corpus luteum because it produces progesterone, the fetal sac because its estrin content continues to be comparatively poor, while the bulk of the pregnancy remains small.

Estrin (also called female-sex hormone, theelin, progynon, folliculin, and by still other names) occurs not only in the fluid of the ovarian follicle, but also in the placenta, fetal membranes, and amniotic fluid. Unquestionably, it participates in the preparation of the uterus for the act of labor; but its sphere of influence has not been definitely ascertained. Some writers believe it sensitizes the muscle and nerve elements of this organ. Furthermore, Robinson and his coworkers¹² assume hypothetically that estrin stimulates the posterior lobe of the pituitary to elaborate the characteristic hormone, distinguished for its ecobolic properties.

If the pregnancy is normal the administration of estrin to women never causes abortion, according to Robinson, Datnow, and Jeffcoate; on the other hand these authors found the same treatment effective whenever a dead fetus was retained. Among twelve cases of missed abortion given massive doses of estrin, only two failed persistently to react, three responded following additional medication, the remaining seven expelled the contents of the uterus spontaneously, "after an interval up to seven or eight days." Parenthetically, estrin had no effect upon several patients with incomplete abortion and one with hydatid mole.

Such results will inspire further trial of this therapeutic agent, especially since Spielman, Goldberger, and Frank¹³ reported several years ago that estrin disappears from the mother's blood after death of the fetus. During normal pregnancy its presence in the blood has long been recog-

nized, and its abundance in the urine was recently reaffirmed by Cohen, Marrian, and Watson,¹⁴ who add: "the hormone first presents itself in an adynamic form, as estrone and estriol, in combination with glucuronic acid." At the approach of labor the bond is broken, liberating a potent form of estrin. Ultimately the functions of this endocrine secretion will be defined more clearly. At present it appears that during normal pregnancy two hormones, progesterone and estrin, hostile to each other in some respects, are equilibrated; preliminary to labor the latter gains the upper hand. Conversely, the inertia responsible for the prolonged retention of a dead fetus is probably associated with a deficiency of estrin and a surplus of progesterone.

TREATMENT

Radical treatment of missed abortion, either medical or surgical, must inevitably await proof of the death of the fetus. Subsequent delay will be governed largely by the patient's attitude, a permissible concession, for procrastination rarely leads to complications. Nevertheless, with the diagnosis established, the physician should recommend active treatment since the removal of the derelict pregnancy alone will restore the normal functions of the reproductive organs.

In due time the therapeutic merits of estrin will be fully ascertained. At present commercial preparations of the hormone are expensive and the correct dosage has not been announced. On theoretical grounds it was predicted that pituitrin would act weakly during the early months of pregnancy because of the antagonism of progesterone. So it does. Induction by means of bougies contributes infection too often and, besides, it frequently provokes bleeding. Therefore, when therapeutic abortion has been agreed upon, the logical choice of treatment today is surgical. If the attending physician in all conscience feels the need of assistance, there will be ample time to make such arrangements as best assure a satisfactory end-result.

In general the operation consists of dilating the cervix, loosening with a finger the retained material and removing it by the use of blunt forceps. A sharp instrument, a curette, may perforate the uterus. At times vaginal hysterotomy becomes the preferable operation. Irrespective of the type of procedure selected, preliminary preparations for packing the uterus are imperative to obviate postpartum hemorrhage.

As a rule the convalescence will be smooth, but in one case of this series, that of hematoma mole, excessive bleeding continued for days after removal of the pack. It ceased following radiation, employed at the request of the husband, a physician; sterility ensued. Likewise, the woman with chronic pelvic inflammatory disease has not become pregnant again. The remaining three patients have borne children subsequent to their experience of missed abortion. Finally, it should be noted that a few, very few, cases of repeated missed abortion have been recorded in medical literature.

SUMMARY

No longer a rare complication, missed abortion has had relatively slight comment in medical literature because until recently very little was known about the cause of the underlying uterine inertia when a dead fetus is retained. Negative clinical manifestations and relief from the common ailments of the early months of pregnancy mislead patients to believe that all is going well. Sound diagnosis will supplement the observation of arrested uterine growth with proof that the hormonal urine reaction has ceased to be positive. Anatomical studies reveal that the fetus dies before the placenta loses its vitality. Endocrinal research indicates a deficiency of estrin, a surplus of progesterone; a situation harmonious with persistent uterine inertia. In general treatment remains surgical, since drugs are almost always inert and hormonal therapy has not as yet been accurately defined. At operation two hazards must be kept in mind, perforation of the uterus and profuse hemorrhage.

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DISCUSSION

C. FREDERIC FLUHMAN, M.D. (Stanford University Hospitals, San Francisco).—The condition of "missed abortion" is not only of considerable importance from a clinical standpoint, but it presents certain problems which are inevitably associated with the cause of the onset of

labor. As Doctor Slemmons points out, modern investigators have sought to explain this phenomenon on an endocrinologic basis, and three main factors have been considered: (1) progesterin, a specific product of the corpus luteum, which inhibits uterine motility; (2) estrin, which sensitizes the smooth muscle of the uterus so that it responds more readily to the oxytocic action of (3) the posterior pituitary principle. On the basis of animal experimentation, it has been possible to expound a number of theories; but it must be remembered that the problem in the human is complicated by the appearance of a new hormone which is not found in nonpregnant individuals nor under any conditions in ordinary laboratory animals. This substance, the "chorionic gonadotropic hormone," is present in large quantities in women during gestation, and its exact rôle in the physiology of pregnancy has not been determined. Although our attention is necessarily directed to an endocrinologic disorder as possibly responsible for the prolonged retention of a dead fetus and placenta in the uterus, one cannot escape the consideration of a disturbance in the uterus itself as a potential factor.

There is nothing to add to Doctor Slemmons' discussion of the clinical manifestations, diagnosis, and treatment of missed abortion. On the Lane obstetric and gynecologic services, only eleven cases have been indexed under this diagnosis over a period of twenty years. I do feel, however, that the condition is more common than these figures and those quoted by most authors indicate, and we are very grateful to Doctor Slemmons for bringing this subject to our attention.

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FRANK W. LYNCH, M.D. (University of California Medical School, San Francisco).—Doctor Slemmons presents a thorough review of this rare condition and illustrates nearly all of its phases with cases from his own practice. His arguments are so convincing that there is very little that a discussor can say. As Doctor Slemmons states, the complication in the past was shrouded with mysticism. Indeed, at one time it was believed that when the woman passed by the threatened abortion and did not extrude the contents of pregnancy, she in all likelihood would not abort until her expected date at term.

Before the discovery of the hormonal reactions of pregnancy, the diagnosis of the death of an early pregnancy was always a most difficult matter. Time in the final analysis gave the diagnosis; yet, when the patient was sick and when it did not seem reasonable to delay treatment more than absolutely necessary, confusion often reigned. It would not seem possible that there might be doubt as to whether the uterus had or had not increased in size from the third to the fourth month, yet very often there is such doubt. When Chadwick's sign had been present and disappeared, there was more than presumptive evidence that something was wrong. Yet Chadwick's sign very often does not appear until the last months of pregnancy. Even the blue discoloration along the middle of the anterior vaginal wall, extending to and about the anterior cervical lip, may be wanting. Yet, when you inspect the vagina of a woman with a missed abortion of six weeks to two months' standing, you will find it bears but little resemblance to the ordinary uterus of a four or five months' pregnancy.

The symptomatology is very interesting. Many women, but not all, develop malaise and symptoms that suggest protoplasmic poisoning. I have often wondered how many times I have been responsible for symptoms when I introduced doubt into the mind of some of my patients that the pregnancy was not developing. Certain it is that few of my patients were happy or contented while I was watching for definite proof that the case was a missed abortion. It is of interest, also, that the animal that has a missed abortion and absorbs the products of conception seldom, if ever, again becomes pregnant.

✽

NORMAN H. WILLIAMS, M.D. (1052 West Sixth Street, Los Angeles).—The subject of missed abortion is appropriate to a program of this kind; it is too seldom discussed. Medical literature relating to it is surprisingly scant. One who supervises obstetrical patients observes the occasional case, but Taussig's estimate of missed abortions as 10 per cent of all abortions seems high. Presuma-

bly the variable incidence, as stated by various observers, results from the present loose definition. Certainly, a definition dependent upon the time elapsing between the death of the fetus and its expulsion, or removal, from the uterus is uncertain; although this may be an aid to diagnosis. A definition based upon a negative biologic test for pregnancy seems more logical.

As Doctor Slemmons suggests, the probable cause of the inertia lies in the unbalanced hormone production, the stimulus to uterine contractions thus being diminished. In all probability, cases will now be observed more carefully as experimental hormonal study becomes better standardized, and its clinical application made more certain.

In the event of missed abortion quite as much tact and judgment are required in handling the mental attitude of the patient and family, as in the treatment of the obstetrical complication. Carelessness there frequently leads to misunderstanding between the patient and her physician. One plausible reason for dissatisfaction lies in the fact that accurate diagnosis must necessarily be delayed; another relates to the infrequency of missed abortion. The laity is not familiar with such a possibility.

It is sound practice to empty the uterus as soon as the diagnosis is made. Procrastination may lead to embarrassment. In one instance, to my knowledge, missed abortion terminated on a ballroom floor.

THE LURE OF MEDICAL HISTORY†

A RARE BOOK*

REVIEW OF ONE OF THE VOLUMES IN THE GROWING COLLECTION IN THE LIBRARY OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION: FRIAR BARTHOLOMEW'S ENCYCLOPEDIA, BEST SELLER OF THE MIDDLE AGES

By HYMAN MILLER, M.D.
Los Angeles

"BARTHOLOMAEUS ANGLICUS' *De Proprietatibus Rerum*, 1491." So reads the prosaic index card, but far from prosaic is the story behind this card.

Some time between the years 1200 and 1240 A. D., Bartholomew the Englishman, monk of the Franciscan Order, set himself to the task of writing a comprehensive encyclopedia of contemporary lore. Thus was a medieval best-seller born. Busy pens—for this was before the day of the printing press—turned out copy after copy in Latin, Italian, French, Provencal, English, and Spanish. *De Proprietatibus Rerum* (On the Properties of Things)—for such was the name of this book—must have had great popular appeal, for only so can we explain its many translations into vernacular in a world where Latin was the language only of scholars. And only so can we explain the flood of editions which poured forth once 1440 had arrived and Gutenberg had invented printing and the necessary press.

The first printed edition, a Latin one, appeared at Basel about 1470, and by the beginning of the sixteenth century the presses had poured forth nine more Latin, five French, one Dutch, one English, and two Spanish editions. Thus from

†A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* Reprinted from the Bulletin of the Los Angeles County Medical Association.

1470 to 1501, in the first half-century of printing, Bartholomew was represented nineteen times. Not a great number in the 28,000 editions of Incunabula or Cradle Books, but sufficient to entitle him to a place as one of the most popular writers of his time. Nor did his popularity then wane, for by 1582 fifteen more editions of the *De Proprietatibus* had appeared, making, all told, thirty-four printed editions over a period of three centuries, certainly a best-seller, outshining even our modern best-sellers. Incidentally, the last complete edition, an English one, appeared as late as 1907, and as recently as 1933 the *De Proprietatibus* was the subject of a long essay in one of our contemporary journals.

When Doctor Vollbehr, best remembered as the man who amazingly sold the United States Government a million dollars' worth of Incunabula, came to Los Angeles, he was visited by Doctors Dock and Belt and the librarian to see his collection, with the result that the monk, Bartholomew, is now represented on the shelves of our library by a copy of his *De Proprietatibus Rerum*, printed in 1491, and containing Doctor Vollbehr's bookplate of his *Inkunabel-Sammlung*. This Incunabulum takes its place alongside the only other in our library, the *Divinarum Institutionum*, by Lactantius, presented by our friend of San Francisco, Dr. Chauncey Leake.

To bibliophiles, the presence of these books gives a sense of completeness heretofore lacking in our library. To explain this would mean a discussion of the significance of Incunabula in the history of books and all that the word "books" implies. It will suffice to briefly outline what thoughts our copy of the *De Proprietatibus* arouses on being lifted from its protective casing. Despite the suggestion of fragility which this casing and the knowledge of its 446 years of age bring forth, it is a good, sturdy, substantial book, as it had to be when it was loaned out to medical students for a set fee, as was done in the medieval precursors of our modern lending libraries. The binding is of vellum, an ancient Latin leaf from some ecclesiastical manuscript, covered with carefully formed characters and decorated initial letters in still brilliant blue and red. On opening the book there is no title page; instead, on the last leaf there is the printer's colophon, which in those early days of printing performed the same function as our modern title-page. Here we find that the book was printed by one known as George Husner in 1491 at Strassburg, or Argentine as it was then called; that the title of the book is *De Proprietatibus Rerum* and the author, Bartholomaeus Anglicus, Ordinis fratris minor. Turning back to the fly leaf we find written thereon in browned ink, "Ex Libris, Ivan Paul Kaid, M. D. 1659." Who was Doctor Kaid?

Turning the page, we reach the table of contents and here we search for some insight into the character of the author and the reason for the popularity of his writing. We see that he has divided his book into nineteen chapters as follows:

1—On God, 2—On Angels, 3—On Rational Animals, 4—On Body Substance, 5—On Man

and His Parts, 6—On Ages, 7—On Diseases, 8—On Earth and Heaven, 9—On Time and Its Subdivisions, 10—On Elements, 11—On Air, 12—On Birds, 13—On Water and Fishes, 14—On Earth and Its Regions, 15—On Countries, 16—On Stones and Metals, 17—On Herbs and Plants, 18—On Animals, 19—On Music, Colors, Hunting.

On leafing through the book we find the text in Latin, arranged in well-printed double columns of Gothic type. Written in a concise yet readable style, interspersed with touches of dry humor and homely comments on everyday life, it is not to be wondered that edition after edition was necessary to satisfy the reading hunger of a populace just beginning to loosen its belt after the mental famine of the Dark Ages.

Lack of space does not permit a more detailed description of, or comments on the character of Friar Bartholomew's encyclopedic knowledge. Even in the thirteenth century his Chapter 7, *On Diseases*, was a bit behind the times. His discussion of catarrh, sneezing, difficult breathing, phthisis, and quotidian fever were somewhat dated, but then, what text is not, even in these days of rapid communication and ceaseless turning of the presses?

Bartholomaeus Anglicus' *De Proprietatibus Rerum*, 1491, rests on our shelves, fit subject for bibliophilic gossip. May its tribe increase.

1136 West Sixth Street.

CLINICAL NOTES AND CASE REPORTS

CONTRACTION RING DYSTOCIA: TREATMENT WITH EPINEPHRIN

REPORT OF CASES

By BENJAMIN BAKEWELL, M.D.
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TWO patients, suffering from contraction ring dystocia, are here reported:

CASE 1.—Mrs. C., age 23, a healthy young primipara with history and physical examination negative, missed her period in November, 1933, and went through a normal and uneventful pregnancy. She went into labor July 28, 1934, and accomplished a normal delivery twenty-four hours later after a second stage of only thirty-five minutes. She received pentobarbital and scopolamin in the first stage and gas-oxygen in the second. Her labor developed slowly but normally, and her expulsive pains were regular, strong, and effective.

After the delivery at 3:36 a. m., it was noted that there was exceptionally little blood loss. While waiting for the delivery of the placenta a second-degree episiotomy was repaired, and immediately thereafter, at 4 a. m., an unsuccessful attempt was made to deliver the placenta by the usual methods, and one ampoule of pituitrin was given. At 4:35 a. m., one hour after the delivery of the baby and after a number of futile attempts to deliver the placenta, a manual extraction was attempted and one hand was passed through the dilated cervix into the uterus. The condition there encountered was strange and unusual to a degree. The hand easily entered the cervix, but instead of passing up into the open uterus, it encountered a funnel of contracting uterine wall ending in a tight rigid ring through which it was impossible to introduce even a finger. It was at once evident that here was a typical hour-glass contraction of the uterus.

COMMENT

The problem then immediately developed itself:

What measures must be taken to get past the obstruction and deliver the placenta? A contraction ring always develops below or around some object, whether it be the child's body or the placenta, and the danger to the mother lies, not in the ring itself, but in the necessity for the removal of that which cannot be allowed to remain in the uterus.

The first question was, is this an immediate emergency? Must something be done without a moment's waste of time? The answer was, no. There is perhaps only one purely obstetric third-stage emergency which must be acted upon immediately, and that is hemorrhage. In this case there was not only no hemorrhage but, as already stated, there was less than the normal amount of bleeding. I must confess here that my memory did not bring to mind any routine, usually effective method of relaxing the contraction, and my first reaction was that I was facing the necessity of forcing my way through the ring. This procedure must be undertaken after preliminary attempts at relaxation with deep anesthesia, morphin and atropin, and I visualized, of course, all the possible complications of such an undertaking—shock, hemorrhage, infection, or possibly even rupture of the uterus—and was appalled at subjecting my patient to this experience, normal and uncomplicated as her labor had been up to this period. It was then suggested that epinephrin might be tried to bring about a relaxation of the contraction, and 10 minims was given hypodermically and repeated fifteen minutes later. The hand was again introduced into the uterus, and the ring was felt to slowly give way under moderate pressure. The hand finally slipped through and an adherent placenta was encountered. This was detached by gently slipping the fingers under the adhesions, and delivered. The puerperium was uneventful, and the mother and her child were discharged two weeks later in normal condition.

A review of the literature at my disposal was then undertaken to determine what procedure was advised to be followed in hour-glass contraction. De Lee's "Practice of Obstetrics" cannot be found to more than mention this condition, citing it as a cause of postpartum hemorrhage. No suggestions are given as to its etiology or treatment. However, in discussing tetanic or Bandl's ring contraction about the infant, deep anesthesia and possibly cesarean section is advised.

"Gynecology and Obstetrics" by Curtis, published in 1933, is equally sketchy in regard to hour-glass contraction. The condition is mentioned as occurring, and deep ether anesthesia is advised. In discussing Bandl's ring contraction, deep ether anesthesia is suggested. It states that spinal anesthesia has been tried with good results, and quotes Rucker as saying that five minims of adrenalin may be effective.

I was unable to find any reference in any of our magazines for the last five years to hour-glass contraction, but did find several pertinent articles in regard to Bandl's ring contractions and allied conditions, all, however, very recent.

Dr. Pierce Rucker was evidently the first to suggest the use of adrenalin in contraction ring dystocias. He published an article in 1927 wherein he reported two cases in which the spasm was relaxed by the injection of five minims of adrenalin. He suggested that the spasm is caused by stimulation of the bulbo sacral nerves, while the relaxing mechanism is controlled by the sympathetic fibers. It is these latter that are stimulated by adrenalin. In 1923 Urner reported a case of uterine inversion in which the resultant cervical and uterine spasm was relaxed by gas-ether anesthesia, atropin sulphate, grain 1/150, and one-half cubic centimeter of adrenalin solution. The relaxation was sufficient to permit the inversion to be relieved.

The physiological action of epinephrin is of interest in this connection. Adrenalin is said to affect the plain muscles through stimulation of the sympathetic fibers, so that the result of its action depends upon whether these fibers produce contraction or relaxation. The well-known clinical effect of contracting the skin arterioles, as in the treatment of urticaria, or relaxing the bronchial tree, as in the treatment of asthma, are cases in point. Epinephrin also relaxes certain spasms of the intestinal tract. There is apparently still some confusion as to its exact effect on the muscles of the uterus, but the preponderance of opinion is that this effect is to relax them.

In 1930 Rudolph and Ivy published an article on the physiology of the uterus in labor of the dog and the rabbit. They studied the effect of various drugs on the uterus of these animals while pregnant and during labor, and concluded that, experimentally at least, epinephrin abolishes temporarily the spontaneous activity of both the pregnant and nonpregnant uterus of the dog *in situ* and also the activity excited by the use of pituitrin and ergotamin.

In another article, published by Ivy, Hartman and Koff in 1931, on the contractions of the monkey uterus at term, it is stated that pituitrin causes spastic contraction over the entire uterus followed by intermittent contractions without full relaxation, while epinephrin causes a primary contraction followed by temporary relaxation. They also state that epinephrin abolishes the contractions due to pituitrin and ergotamin.

The second case of contraction ring was encountered in a patient of Dr. William E. Johnson, and was as follows:

CASE 2.—Mrs. L. S., age 30, gravida three, para one, gave a history of having had a tubal pregnancy with operation seven years ago, and one induced abortion. Her last menstruation occurred May 17, 1934, and she went through a normal pregnancy, going into labor at 8 a. m. January 29, 1935, about three weeks before term. The membranes were ruptured artificially at 11 p. m., and at 12:50 a. m. she received quinin sulphate, grains ten, to stimulate lagging pains. She also received nembutol and hyoscin in the first stage. Finally, instrumental delivery being indicated, Kielland's forceps were applied under gas-oxygen anesthesia and the head delivered. Some difficulty was encountered in delivering the shoulders, as they seemed not to come down properly, but they and the arms were finally delivered. From this point no more progress could be made, even with repeated strong traction. This appeared, on the face of it, to be a strange dilemma. The large head, the slightly smaller shoulders, delivered and

yet the body, pelvis and legs resisting delivery. The only possible explanation seemed to be a large fetal tumor. External palpation did not furnish any clue.

The next step to be taken was to explore as thoroughly as possible the cavity of the uterus and the retained portion of the child, and for this purpose the hand was slipped with considerable difficulty up along the baby's body until the fingers reached the level of the lower border of the ribs, where there could be felt a resistant band of hard contracted muscle about the body through which it was impossible to pass more than the tips of the fingers, and this only by depressing the soft tissues of the infant. Again it was evident that we were confronted with a contraction ring. One cubic centimeter of adrenalin was given at once, and a few moments later, with traction on the head and shoulders, the child slowly delivered. The infant was found to be an ascitic monster, with an abdomen measuring 40 centimeters in circumference and with a double hydronephrosis, and it was this distended abdomen that was caught behind the contraction ring.

Here again epinephrin seems to have been the instrument by which a serious situation was changed into one of very little moment.

COMMENT

These two cases are reported that we may call attention to the use of epinephrin in contraction rings; but they may also be used to bring out another suggestion. It would seem to the author that we are too prone to force the uterus in situations where, unknown to us, the unconscious nervous mechanism seems to realize that further expulsive effort may be useless or dangerous.

In the first instance, the very common practice of administering pituitrin in the third stage probably precipitated the contraction ring spasm in a uterus containing an immovable adherent placenta; while in the second case the laboring, overloaded uterus was whipped into a spasm with quinin. Neither of these labors were long nor exhausting, as is usually the case where a contraction ring develops; so that it seems reasonable to lay the blame on the oxytoxics for these two cases of contraction ring dystocia.

1421 State Street.

PHARYNGO-ESOPHAGEAL DIVERTICULUM

By JOSEPH E. TILLOTSON, M.D.
Woodland

DIVERTICULUM of the pharynx is an acquired hernia of the mucosa and submucosa, between the fibers of the inferior constrictor muscle of the pharynx or between the fibers of the cricopharyngeus. The pouch develops in the middle part of the posterior wall. Anatomically the pouch is of pharyngeal origin, but its symptoms are referable to the esophagus which is stenosed through compression by the pouch.¹ The first case of this type was reported during the time of William Hunter, and the specimen is still preserved in the Hunterian Museum, Glasgow.² Since then cases have been reported at different times, though the lesion would seem to be relatively uncommon. In a collected series of 878 patients suffering from pharyngeal or esophageal lesions,



Fig. 1.—V. S. P. Age 59. Large pharyngo-esophageal diverticulum filled with barium mixture. It is directed toward the right side and extends into the upper mediastinum. There were marked symptoms; return of undigested food, delayed swallowing, paroxysms of coughing, and dyspnea.

McMillan³ reported 3 per cent as pharyngeal diverticula. Carcinoma of the esophagus, the most common type lesion in this group, was ten times more frequent than the diverticulum.

REPORT OF CASE

V. P. S., male, age fifty-nine, was admitted to Yolo County Hospital, Woodland, California, January 25, 1936. Symptoms were of eight years' standing, and developed gradually until the last six months, when they progressed rapidly and became marked. The first difficulty noticed was that food seemed to catch on swallowing. Undigested pieces of food often returned into his mouth involuntarily. Other people would finish a meal, while he would only begin to eat. During the last six months there were frequent paroxysms of coughing and dyspnea. The patient lost weight; became apprehensive; was fearful of going to sleep; deliberately lived near an emergency hospital, where he might receive hypodermic injections of adrenalin, which temporarily relieved the asthma-like paroxysms of cough and dyspnea.

A nontender fullness in the lower right side of the neck was palpable; at times it changed in size. A barium film showed a well-defined pouch directed toward the right and extending into the upper mediastinum, shown in Figure 1. Dr. R. S. Tillotson examined the patient with esophageal speculum and reported the mouth of the diverticulum was entered by the instrument without difficulty, and that the subdiverticular opening of the esophagus was identified anteriorly.

At operation the anesthetic used was evipal intravenously. Preliminary to this a small rubber tube was passed through the nose to the stomach. An incision was made along the anterior border of the sternomastoid muscle, from the superior border of the thyroid cartilage to the suprasternal notch. The anterior jugular vein was ligated; the deep cervical fascia was divided; then the omohyoid muscle divided; the thyroid and larynx retracted medially, and the carotid vessels laterally. The sac was fairly easy to identify, as it came out from between the esophagus and the bodies of the lower cervical vertebrae toward the right and into the upper mediastinum. It was freed to its junction with the pharynx. When isolated, to the touch it felt very much like a normal gall-bladder and had a somewhat similar gross appearance. Since the pouch went fairly well into the

¹ Jackson, Chevalier: *Bronchoscopy and Esophagoscopy*, Saunders, 1927.

² Moynihan, Berkeley: *The Surgical Treatment and Management of Pharyngo-Esophageal Diverticulum*, Surg., Gynec., and Obst., 54:128 (Jan.), 1932.

³ MacMillan, A. S.: *Statistical Study of Diseases of the Esophagus*, Surg., Gynec., and Obst., 60:394-402 (Feb.), 1935.

mediastinum it was thought best to remove it by two stages. In doing this the general plan outlined by Lahey⁴ was followed. At the first stage, the sac was anchored in the upper angle of the wound. Iodoform packing was inserted below. When the margins of the wound came together, about one inch of the pouch projected beyond the surface level of the skin. At the end of ten days, during which time the wound granulated in, the second stage of the operation was done under evipal anesthesia, and supplemented by a small amount of ether by inhalation near the end of the procedure. During the period between the stages of the operation the patient was fed by a small naso-stomach tube. At this second stage operation, the wound was opened at its upper angle and the sac isolated. To the writer the sac wall seemed thinner than at the first operation. Before the first-stage operation the pouch, over a long period of time, was under considerable distention and irritation by food. The period of rest, through the use of the naso-stomach tube, evidently allowed edema in the pouch to subside. The sac was ligated and excised at its neck, and interrupted sutures through remnants of fascia overlapped the pedicle. A small iodoform pack was inserted into the wound, and it was allowed to heal by granulation. Use of the naso-stomach tube was continued for five days. A fistulous tract resulted in the wound, from which small amounts of fluid and food were expelled with swallowing; but this tract completely closed by the tenth day following the operation.

There was complete relief of symptoms by the operation. The patient ate ravenously and gained ten pounds in two weeks. Difficult swallowing, cough, and dyspnea completely disappeared.

COMMENT

The writer has described a large pharyngo-esophageal diverticulum with marked symptoms. It was operated on with dramatic relief of symptoms. According to the recorded cases of these diverticula reported, the great majority protrude to the left, but this one protruded to the right. The large size of the sac facilitated its isolation. The sac was more thick-walled than might be expected. Microscopic study showed considerable muscle in its wall, which doubtlessly was an hypertrophy due to the long duration of food irritation and recurrent emptying. The sac extended well into the upper mediastinum, and this prompted a two-stage operation as a safeguard against mediastinal infection. There was not primary union following excision of the sac, but the fistulous tract healed without undue delay.

Yolo County Hospital.

GONORRHEAL TENOSYNOVITIS

By JAMES E. REEVES, M.D.
San Diego

IT can be assumed that gonorrheal infections of tendon sheaths are comparatively rare, as no mention of this complication is made in any of several standards works on urology consulted.

An occasional report appears in the literature; one case by Hayward,¹ and another by Murray and Morgan,² in which incision over affected tendon was productive of pus containing Gram-negative intracellular diplococci, morphologically *N. gonorrhea*.

⁴ Lahey, Frank H.: *The Surgical Management of Pharyngo-Esophageal Diverticulum*, Surg., Gynec., and Obst., 51:227-236 (Aug.), 1930.

¹ Hayward, H.: *Gonorrhea of Tendon Sheaths*, Medizinische Klinik, 27:1683, 1931.

² Murray, D. W. G., and Morgan, J. R. E.: *Gonorrheal Tenosynovitis of the Hand*, Canad. M. A. J., 32:374 (April), 1935.

Gonorrheal tenosynovitis of the long head of the biceps was diagnosed by Zadek³ by means of stained sections of tissue, removed by operation.

There is no doubt that this complication has been observed by others and not deemed sufficiently important to report.

REPORT OF CASE

F. J. M., Corporal United States Marine Corps, white, male, age 27.

The patient was exposed to venereal disease in San Diego, California, on January 5, 1936, and took prophylaxis aboard his ship about four hours later. On January 12, 1936, he noticed burning and frequency of urination, followed in a few hours by a creamy urethral discharge. Coincident with appearance of the discharge, the patient bruised the dorsum of his right foot. When he reported to the Sick Bay he complained of marked pain in the foot, in addition to a urethral discharge. On admission, January 13, 1936, he presented the following picture: Temperature, 102 degrees Fahrenheit; pulse, 100; R, 18; urine normal; white blood cells, 19,500; bands, 13 per cent; segs., 50 per cent; lymphocytes, 27 per cent; mononuclears, 10 per cent. Smear of urethral discharge revealed many pus cells, many extracellular and few intracellular Gram-negative diplococci, morphologically, *Neisseria gonorrhoea*. Dorsum of right foot was swollen, tender, and erythematous. There was a profuse, creamy urethral discharge.

The patient was put to bed with foot elevated, and application of constant external heat. Anterior urethral irrigations with 1 to 10,000 potassium permanganate solution were begun.

Temperature for the first six days following admission varied from 99 to 102 degrees Fahrenheit, and the swelling and erythema over the dorsum of the foot gradually increased.

On January 19, 1936, a fluctuating area over the first of the four tendons of the extensor digitorum longus muscle was incised and yielded about 15 cubic centimeters of serosanguinous pus. Smear of the pus obtained showed many pus cells, and intracellular Gram-negative diplococci, morphologically *Neisseria gonorrhoea*.

A drain was inserted and radiotherapy treatments were begun and given twice daily, using two large, well-padded electrodes and 2,500 M. A. (resonance control) frequency, for twenty minutes. Following the second radiotherapy treatment (using the De Forrest laboratories' 250 watt 18 meter, 16.3 kilocycles apparatus), most of the pain disappeared.

From the day of admission until healing of the foot was complete, the white blood cell count averaged about 20,000 per cubic millimeter, and there was an increase in the number of segmented leukocytes. Normal total and differential white blood counts were obtained from the time healing was complete until he was discharged. As the drainage from the incision lessened, the daily afternoon temperature gradually became lower and reached normal ten days after incision, where it remained until discharge to duty.

Examination two weeks after discharge: found the urine clear, prostate and adnexa normal, no urethral stricture present, and normal motion present in the foot.

CONCLUSION

1. An unusual case of gonorrheal infection of a tendon sheath is presented.

2. Treatment with high frequency current appeared to limit destruction, relieve pain and facilitate healing.

3. Tendon injuries during the initial stages of gonorrhea may possibly precipitate gonorrheal tenosynovitis.

Medical Corps, U. S. Navy, U. S. S. Ranger.

³ Zadek, Isadore: *Gonorrheal Tenosynovitis of the Long Head of the Biceps Brachii*, J. A. M. A., 104:2176 (June 15), 1935.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

PREANESTHETIC DRUGS

I. A PHARMACOLOGIST'S VIEWPOINT*

C. D. LEAKE, Ph.D. (University of California Medical School, San Francisco).—Proper psychic preparation of a surgical patient, by an anesthetist who appreciates something of the psychology of fear and of the means by which the dread of a surgical operation may be minimized, will do much to improve such a patient's general status before the actual anesthetic is administered. But for the average patient, where time is not always available for this procedure, a suitable preanesthetic hypnotic may be necessary to supplement the anesthetist's psychic approach. A preanesthetic hypnotic, however, is not indicated solely for the relief of fear the patient may have for anesthesia; it has a definite function in the actual induction and conduct of the anesthesia. As pointed out so strikingly by Waters and Guedel,¹ such an hypnotic is most useful in lowering the patient's general metabolic level to a point where the anesthetic may be easily and smoothly administered.

Preanesthetic hypnosis certainly reduces the amount of anesthetic agent required, so that during the direct anesthesia more oxygen may be given than would otherwise be the case, were no preliminary depressant agent employed. Thus, with proper preanesthetic preparation, a satisfactory degree of surgical anesthesia may be readily secured even by nitrous oxid and oxygen without pushing nitrous oxid to a dangerous asphyxial concentration, which is frequently necessary without supplementary depression.

Although much general dissatisfaction has been expressed with morphin and hyoscin (scopolamin) as *preanesthetic hypnotics*, they continue to be used quite routinely in the absence of any pressing clinical necessity for something better. Morphin is definitely indicated, of course, as a *preanesthetic analgesic* when pain is present. A consideration of the pharmacology of these agents may be of interest in supporting the independent clinical condemnation of these agents for *preanesthetic hypnosis* years ago by such competent observers as Herb, Gatch, and Bevan.²

The primary effect of morphin is stimulation of the central nervous system, which is promptly masked in humans by a secondary depression. *The stimulating action outlasts the depression.* Thus, after the depression wears off there is increased irritability and cortical excitement, which may be responsible for the initiation of craving

and habit. That is, during the after-period of irritability the individual craves the drug again in order to recover the pleasant euphoria of the depressant stage.³ Another objection to morphin as an adjunct to anesthesia is its tendency to cause constipation, which interferes with a proper post-anesthetic condition. However, the definite stimulation of intestinal musculature by morphin may help greatly in preventing postoperative intestinal stasis.⁴ Furthermore, morphin is not helpful in anesthesia because its action in depressing respiration interferes with the rapidity of absorption or elimination of an inhalation anesthetic. To these three important pharmacologic objections might be added its tendency to disturb carbohydrate metabolism, in a manner not conducive to the best condition of the patient, as reflected in its effect on blood sugar and on the acid-base balance of the blood.⁵ In justice to morphin, however, it should be noted that the clinical opinion, that it interferes with kidney function, has little support when critically examined.⁶ The suppression of renal activity under anesthesia seems to be a reflex effect of irritation of the laryngeal mucous membrane by the anesthetic gases.⁷

There is no doubt, however, that morphin remains the best preanesthetic hypnotic when *traumatic* pain is present. Its amazingly effective action in relieving traumatic pain should not be denied the patient, either before or after the operation, if its use is indicated. The National Research Council is spending a great sum of money annually to finance chemical research at the University of Virginia, and pharmacologic work at the University of Michigan under the direction of Dr. N. B. Eddy, to develop a satisfactory substitute for morphin which will be free from its addiction dangers. The resultant pharmacologic studies are currently appearing in the *Journal of Pharmacology and Experimental Therapeutics*. Meanwhile, a morphin derivative called "dilaudid" was enthusiastically introduced in this country by Alvarez.⁸ Subsequent clinical use has indicated, however, that "dilaudid" has probably the same potential addiction properties as those possessed by morphin. Dr. Norman A. David, formerly of this laboratory, has made an interesting comparison of the two agents.⁹

* Collins, K. H., and Tatum, A. L.: *J. Pharmacol. and Exper. Therap.*, 27:237, 1926.

⁴ Plant, O. H., and Miller, G. H.: *J. Pharmacol. and Exper. Therap.*, 21:202, 1923.

⁵ Leake, C. D., and Koehler, A. E.: *Arch. Internat. de pharmacodyn. et de therap.*, 27:221, 1922.

⁶ Haines, W. H., and Milliken, L. F.: *J. A. M. A.*, 85:1853, 1925.

⁷ Dooly, M. S., and Wells, C. J.: *Am. J. Physiol.*, 90:330, 1929.

⁸ Alvarez, W. C.: *Proc. Staff Meet., Mayo Clinic*, 7:480, 1932.

⁹ David, N. A.: *J. A. M. A.*, 103:474 (Aug. 18), 1934.

* From the Pharmacological Laboratory of the University of California Medical School, San Francisco.

¹ Waters, R. A., and Guedel, A. E.: Personal communication.

² Herb, I. C.: *J. A. M. A.*, 56:1312, 1911. Gatch, W. D.: *Ibid.*, 57:1599, 1911. Bevan, A. D.: *Ibid.*, 57:1821, 1911.

Little rational evidence exists that opium or a mixture of its alkaloids free from non-alkaloidal material ("pantopon") has any advantage over morphin as a preanesthetic hypnotic. Such a mixture of the differently acting alkaloids in opium is an irrational material to use, since not only aggravation of some of the deleterious effects of morphin, as its constipating action, is known to occur by giving it with other opium alkaloids, but indeed few of these other alkaloids have been properly studied, either pharmacologically or clinically, to know how they may act. Scientific therapy demands the use of chemical agents singly for definite effects, avoiding confusing mixtures of any sort. Certainly, preanesthetic hypnosis should be simplified and rationalized rather than complicated.

If there is pain present due to swelling of tissue, then morphin is not as effective as such drugs as amidopyrin, the salicylates or the cinchophens. These antipyretics exert their pain-relieving action, when pain is due to swelling of tissue, by pulling fluids out of such swollen tissue back into the blood stream, as indicated by the careful studies of Barbour.¹⁰

Hyoscin or scopolamin is said to synergize with morphin, enhancing its depressant action, especially on the cortex. The pharmacology of hyoscin has not been very thoroughly studied, and there seem to be few clinical observations of a critical nature on the effects of this drug in connection with anesthesia. Hyoscin is chemically related to atropin and has a similar effect on the autonomic nervous system. This action, as we shall see, may be detrimental in preanesthetic medication. In the absence of any reliable or critical evidence of its usefulness as a preanesthetic hypnotic, little justification exists for its continued use merely because of clinical habit or routine. There is an opportunity here for clinical judgment to evaluate critically its status as an adjunct to anesthesia. Barlow has recently shown experimentally that hyoscin is of no value in nitrous oxid anesthesia and, indeed, it may be detrimental.¹¹

In the effort to find more satisfactory preanesthetic hypnotics which might be substituted for morphin, a number of other substances were studied in my laboratory from the point of view of their effects on the body functions of normal human subjects, in comparison with morphin.¹² We studied especially the action of these various depressant drugs on basal metabolic rate, tactile discrimination, respiration, pulse rate, and blood pressure. We thought our observation might furnish us with objective quantitative criteria for estimating depressant action of the different drugs on the central nervous system. While codein has much to recommend it over morphin as a central nervous system depressant, it is not sufficiently powerful, in our judgment, to justify its use clinically for preanesthetic hypnosis.¹³

The exploitation of sodium amytal suggested that we study barbitol and its common derivatives from this standpoint. *As a result of our observations on normal humans, we may recommend barbitol by mouth as a possible substitute for morphin as a preanesthetic hypnotic, if no pain is present.* In the average adult it may be expected to bring relief from fear and apprehension, and to dispose toward sleep, relaxation and amnesia, in doses of 1 to 1.5 grams, or even higher. It depresses the basal metabolic rate in the same way as morphin, and is otherwise generally depressing. No residual stimulation results, and the psychic disadvantage of hypodermic administration is avoided. It may sometimes cause a cutaneous rash, however, and it is of no use as a hypnotic if pain is present. Subjective reactions to barbitol vary greatly with physical constitution and social background. If the ordinary local anesthetics are to be used, it is definitely indicated since it protects against their toxic manifestations.¹⁴ With spinal anesthesia, the status of which still remains to be established, more of an analgesic effect is needed in the preanesthetic medication, and morphin or amidopyrin is indicated.

We could not find that phenobarbital, or any of the common commercial modifications of barbitol, including "amytal," "dial," "ipral," "neonal," and "phanodorn," have any significant advantages over barbitol as hypnotic agents in man. Indeed, they all showed some disadvantages.¹⁵ Eddy, however, from animal experiments, believes "amytal" has the greatest depressing effect.¹⁶

It is sometimes amusing to the pharmacologist to observe the enthusiasm with which certain clinicians continue to report experiences with new drugs. There seem to be fads and styles with drugs as with clothes. If medical men generally realized the extent to which preliminary and unconfirmed pharmacologic evidence is distorted by drug concerns (usually foreign) for clinical exploitation of new agents, they would undoubtedly be more reserved in expressing clinical opinions. Very few new drugs reach clinical trial in an ideal scientific manner.¹⁷

Sodium amytal was thus overenthusiastically recommended as a general anesthetic when given in strongly alkaline solution by vein. While the induction of sleep and amnesia is dramatic by this technique, it is obvious that the agent is not in itself sufficiently analgesic to be a satisfactory general anesthetic except in dangerous doses. There is too narrow a margin of safety between the dose causing real anesthesia and that depressing the medullary centers to a lethal level. Sodium amytal thus falls in the class of anesthetic adjuncts, as now admitted by its original proponents.¹⁸ The intravenous, or even oral, use of this

¹⁰ Barbour, H. G.: *J. Pharmacol. and Exper. Therap.*, 29:427, 1926.

¹¹ Barlow, O. W.: *J. Pharmacol. and Exper. Therap.*, 46:131, 1932.

¹² Anderson, H. H.: *Proc. Soc. Exper. Biol. and Med.*, 27:102, 1929.

¹³ Chen, M. Y., and Anderson, H. H.: *Proc. Soc. Exper. Biol. and Med.*, 27:719, 1930.

¹⁴ Tatum, A. L., and Collins, K. H.: *Arch. Int. Med.*, 38:405, 1926. Knoefel, P. K., Herwick, R., and Loevenhart, A. S.: *J. Pharmacol. and Exper. Therap.*, 39:397, 1930.

¹⁵ Leake, C. D., Chen, M. Y., and Anderson, H. H.: *J. Pharmacol. and Exper. Therap.*, 40:215, 1930.

¹⁶ Eddy, N. B.: *J. Pharmacol. and Exper. Therap.*, 33:43, 1928.

¹⁷ Leake, C. D.: *J. A. M. A.*, 93:1632 (Nov. 23), 1929.

¹⁸ Zerfas, L. G., and McCallum, J. T.: *Anesth. and Analg.*, 8:349, 1929.

substance as a routine preanesthetic hypnotic is not justified until it has been more thoroughly evaluated in comparison with what, in our opinion, is as satisfactory, and certainly a less expensive official drug, barbital.

A new German barbital derivative, called "evipal," has recently been exploited for intravenous anesthesia. It is subject to the same general criticisms as sodium amytal by vein. It has, however, one advantage in that it seems to be fairly rapidly destroyed in the body, so that recovery from an anesthetic dose is, consequently, rapid.

Stormount¹⁹ and associates have directly studied the preanesthetic value of various barbitals in nitrous oxid and oxygen anesthesia in rats. They found that 85 per cent nitrous oxid with 15 per cent oxygen (enough to prevent anoxemia at sea level) will anesthetize with 30 per cent of the average lethal dose of "dial" and "neonal," but that 45 per cent of the average lethal dose of "amytal," barbital, and phenobarbital is required to give this same effect. In man, however, we found barbital the most satisfactory depressant of the series, in so far as lowering of the basal metabolic rate, dulling of tactile discrimination, and tending toward sleep are concerned. Amytal and phenobarbital, we noted, increased the basal metabolic rate except in high doses. The relative merits of the several derivatives of barbital as preanesthetic hypnotics remain, therefore, to be further evaluated before surgeons are justified in using any of its modifications for this purpose, in preference to the well-studied parent substance, barbital.

It is hardly possible that any of the other multitudinous commercial derivatives of urea exploited so vigorously, especially by the Germans, have any great advantage over barbital in this regard. One of these, "pernocton,"²⁰ includes bromin, which introduces another difficult depressant factor to evaluate. Chemists have sought for some time to develop barbital derivatives which are rapidly destroyed or removed from the body. One of these, "evipal," has already been mentioned. In this country the Lilly and Abbott laboratories developed, almost simultaneously, an identical compound called, by the former, "pentobarbital," and by the latter, "nembutal." These barbitals are relatively short in action, but the effects of repeated administrations must still be carefully studied in order to determine whether any residuum remains which may lead to the danger of chronic poisoning.

Particularly to be condemned are combinations of barbital or its derivatives in fixed proportions with amidopyrin, such as "allonal," "cibalgin," or "pyraminal." Aside from the violation of rational therapy by such mixtures of a hypnotic with an analgesic in fixed proportions without regard to the indications of the individual patient, as scored by the Council on Pharmacy and Chemistry,²¹

Koppanyi and Lieberman²² have shown that the analgesic component of such mixtures is eliminated much more rapidly than the hypnotic, so that grave danger of the cumulative effect of the latter is present if the dose is repeated to get continued analgesic action.

The same general considerations hold for tribrom-ethyl alcohol ("avertin"). Enthusiastically advocated as a general anesthetic by those who hitherto rarely saw good modern anesthesia by gas and oxygen, more critical clinical opinion now recognizes this agent more properly as merely an adjunct to anesthesia.²³ The difficulties of preparation, the dangers of toxic decomposition, the necessary mode of administration and the pharmacologic action of the drug limit its usefulness, as in the case of sodium amytal by vein, to abnormally apprehensive or excited patients, and then in doses not so high as to give partial analgesia with dangerous depression of the vital centers—that is, not much more than 75 milligrams per kilo body weight. It is peculiar that physicians should become so excited over tribrom-ethanol by rectum, when paraldehyd, a much cheaper and safer drug, was used in this manner as a preanesthetic agent many years ago. The enthusiasm over tribrom-ethanol has revived interest in paraldehyd as a safe and effective preanesthetic hypnotic.²⁴

The prolonged action of tribrom-ethanol and of the barbitals, especially sodium amytal by vein, may have a useful postoperative effect in keeping the patient quiet and asleep. But often with the barbitals motor excitement may supervene, especially if large doses are used, and contrariwise, if the dose is too high, such severe depression may result that constant attention is needed to prevent accidental asphyxiation or other complications.

The central nervous system depressant action of magnesium sulphate and its dramatic antagonism by calcium chlorid were demonstrated experimentally by Meltzer and Auer²⁵ in 1908. Clinically developed by Gwathmey²⁶ for aid in preanesthetic hypnosis, its possible field of service has become somewhat neglected in the undignified rush to help exploit the newer commercialized drugs. The characteristic feature of its action is depression of motor tone and activity, so that it would seem to be especially indicated in patients with motor excitement or with so much muscular tone as to interfere with satisfactory surgery. One or two cubic centimeters of a 50 per cent sterile solution injected intramuscularly is an average dose for this effect. It is claimed that the drug synergizes with morphin and the general anesthetics, so that care must be observed in its use with these agents.

Atropin was introduced as an adjunct to chloroform anesthesia, in order, by paralyzing the pe-

²² Koppanyi, T., and Lieberman, A.: *J. Pharmacol. and Exper. Therap.*, 39:177, 1930.

²³ Edwards, G.: *Brit. M. J.*, 2:713, 1929. Waters, R. M., and Muehlberger, C. W.: *Arch. Surg.*, 21:887, 1930. Wood, D. A.: *Calif. West. Med.*, 33:719, 1930.

²⁴ Stewart, J. D.: *Brit. M. J.*, 2:1139, 1932.

²⁵ Meltzer, S. J., and Auer, J.: *Am. J. Physiol.*, 23:141, 1908.

²⁶ Gwathmey, J. T.: *J. A. M. A.*, 85:1482, 1925.

¹⁹ Stormount, M. F., et al.: *J. Pharmacol. and Exper. Therap.*, 39:165, 1930.

²⁰ Raeschke, J.: *Klin. Wchnschr.*, 8:1800, 1929.

²¹ Council on Pharmacy and Chemistry: *J. A. M. A.*, 86:1853 (June 12), 1926.

ripheral endings of the vagi, to prevent reflex stoppage of the heart during the induction stage. With ether anesthesia it is advocated on the basis of preventing the "mucous inundation" caused by the irritant action of ether vapor on bronchial mucous membranes, and/or suppressing salivation. With modern gas-oxygen anesthesia, especially when the excellent rebreathing technique devised by Waters is used²⁷ (in which every aspect tends so nicely to conserve the physiologic balance of the patient), these excuses for the use of atropin do not exist. This drug should certainly not be used routinely.

Osborne points out²⁸ that it is not good practice from the standpoint of physiology to interfere with the protective function of bronchial secretion, as long as satisfactory cough reflex is present to prevent the formation of mucous plugs with the danger of resultant atelectasis. The bronchial and intestinal relaxation induced by atropin cannot be considered beneficial to the postoperative condition of the patient. Atropin further tends to cause some cortical stimulation, and surely the dryness of the mouth it produces is no joy to the patient already thirsty in the usual postoperative state. Atropin, therefore, in my opinion, should be reserved for use when specially indicated, as in chloroform or extensive ether anesthesia, or when there is reason to expect an embarrassing mucous or salivary secretion during the operation.

In conclusion, routine preanesthetic medication is to be strongly condemned. So also is an undignified rush to aid the clinical exploitation of new commercial agents not yet properly evaluated pharmacologically. Each patient should be separately considered, from the standpoint of preanesthetic hypnosis, with regard to type of chemical agent to be employed and, if necessary at all, dosage and mode of administration. The clinical evaluation of new agents should be left to university or research hospitals, where critical study with proper control methods are most likely to be found.

* * *

II. AN ANESTHETIST'S VIEWPOINT

MARY E. BOTSFORD, M. D. (807 Francisco Street, San Francisco).—The selection of the drug and estimation of dosage are of as much importance in producing and maintaining safe and efficient anesthesia as the agent employed and the method of administration. Modern medicine requires that the patient come to the operating table in the best attainable physical and psychic condition. Where formerly the choice was limited to a few hypnotics, pharmacologic progress has increased their number so that it is now possible to fill the need of the individual case.

The various forms of *opium* have not so far been superseded by any of the newer discoveries, but its action may be assisted and modified by such adjuvants as the barbiturates, tribromethanol,

evipal, paraldehyd, etc. According to Hewitt, idiosyncrasy to morphin exists in only 2 per cent of cases. It is more frequent in the *barbiturate group*. With the latter it is possible, in adults at least, by giving a minimal dose the night before operation, to establish the individual reaction, and the preanesthetic dose may be prescribed accordingly. The great value of the barbiturates lies in their hypnotic effect and, if given at least an hour before operation, they prevent the frequent stage of excitement which, by accelerating cardiac and respiratory action, lengthens the period of induction and necessitates the use of a greater amount of the anesthetic agent. When followed by morphin or pantopon, a quiet induction and smooth maintenance of inhalation anesthesia are ensured.

Avertin is of value in apprehensive patients and many minor operations, as well as brain surgery, where inhalation anesthetics increase hemorrhage, may be performed under its effect without further anesthetization. The addition of atropin to the dose of morphin is a routine procedure, which is strongly to be condemned, notwithstanding the fact that a large majority of the adult patients operated in this country are premedicated with a one-sixth to one-quarter grain of morphin and 1/150 to 1/120 grain of atropin. There has not yet been discovered a better preanesthetic drug than morphin, but the addition of atropin often nullifies its benefits. Atropin is the physiologic antagonist of morphin, whose sedation—psychic, cardiac, respiratory, and secretory—is of the utmost value in producing and maintaining efficient and safe anesthesia. The purpose of atropin is said to be its action on salivary glands, and if given alone it does decrease secretion; but with any form of opium it overcomes the effect of the latter in controlling mouth secretions. Further, its stimulating effect upon respiration is a definite disadvantage, particularly in abdominal surgery; the increased diaphragmatic activity interfering with intestinal relaxation, resulting in the necessity for producing too deep anesthesia.

Ether is in itself a cardiac and respiratory stimulant. The gaseous anesthetics, nitrous oxid, ethylene, and cyclopropane have little effect on cardiac and respiratory functions, when anoxemia is not present. The only logical place for atropin is in chloroform anesthesia, where respiratory stimulation is necessary.

Scopolamin, which fell into disfavor some years ago because of deaths resulting from an impure product, is being much used in combination with morphin. Sollmann finds it sedative in all doses, while even moderate doses of atropin are excitant.

Protection of the psyche from distressing mental impressions is of even greater importance in children than in adults. Psychiatrists and psychologists have demonstrated abundantly the evils, often developing years later, of mental complexes definitely traced to early impressions caused by fear, and there is no more potent factor in its production than the dread of operation, the awe-inspiring preliminaries, and the often forcible administration of anesthetics.

²⁷ Waters, R. M.: Arch. Surg., in press.

²⁸ Osborne, W.: Lecture on Surgical Applications of Physiology, San Francisco, 1930.

The addition of the barbiturates has helped immeasurably in providing an escape from the depressing effect of fear by influencing the nervous system sufficiently, when administered preanesthetically, to produce unconsciousness, or at least indifference to the sights and sounds incident to transportation to the operating room and the induction of anesthesia. The mass of evidence available in the literature, based on research conducted by pharmacologists, anesthetists, and surgeons, has proved conclusively the value of the barbiturates.

Determination of the drug and dosage should depend not only upon the kind of operative procedure, but the age, physical and mental condition of the patient.

* * *

III. A SURGEON'S VIEWPOINT

JOHN HOMER WOOLSEY, M. D. (Woodland Clinic, Woodland).—The use of preanesthetic drugs, in the opinion of the majority, marks great advancement in the medical science because of the additional comfort and care they afford our surgical patients. As human beings endowed with comprehending minds, we reason and thereby suffer mental as well as physical injury. To the average patient there is nothing more important than the anesthetic because of the fear of giving up control of the vital processes. Preanesthetic drugs, when properly used, eradicate fear and assist in mental and physical rest. They help prepare the patient to undergo the necessary physical effort of any surgical procedure.

Safety to the Patient

The safety of the patient is always the paramount factor. Preoperative drugs should not be so powerful as to prevent the anesthetic agent from being the controlling factor. When seen in the operating room, it is true that the effect of a massive dose of preanesthetic medication generates enthusiasm, but its complications and sequelae, when observed in the postoperative period, dampen this enthusiasm.

The desired effect of preoperative medication is to quiet the patient, to eliminate apprehension, to enable the general anesthetic agent to control the patient's respiration and final relaxation, and to assist in a prompt postanesthetic recovery. How are we to obtain these?

In the first place, standardization of preanesthetic medication is impossible. It is an individual problem. Not only body weight, but age, sex, degree of nervousness, metabolic rate, and temperature are influential factors. A patient's susceptibility must, therefore, be individually estimated. This can be done by the use of divided dose—that is, a portion the evening before and another portion preoperatively the morning of the operation. Observance of the patient's reaction to a preanesthetic drug given the previous evening will more accurately determine the amount for immediate preoperative medication.

The postanesthetic recovery of a patient should be sufficiently prompt to allow voluntary response within one hour. Prolonged depression leads to

retained secretion in the respiratory system and a greater tendency to partial pulmonary collapse. Instances of the dropping back of the tongue, with obstruction of the glottis and the interference of respiration, have been reported. It is also desirable to have the patient's cooperation in remaining covered, and in the administration of parenteral fluids.

Influential Factors

Body weight is the most important influential factor in determining the dosage of the preanesthetic drug. Heavily muscled individuals, such as athletes and workmen, demand more drugs than those whose weight consists of a considerable degree of fat.

Age is of importance, since under twelve years and over sixty years, the barbituric acid derivatives do not have a uniform effect and afterward are too depressive. Also in the aged, certain forms frequently stimulate unpleasant dreams and fearful memories, and in those suffering from cerebral disease toleration of these drugs is poor.

Because of its importance, let us reiterate, much depression of the respiration in the very young, the old, and in those with cerebral disease occurs with the preanesthetic drugs, and they must be used, therefore, with caution. In children drugs by mouth are not always readily absorbed, and rectal administration is often disturbing and occasionally expelled.

Sex plays a part chiefly because of the increased musculature of the male which demands, accordingly, more or less of a drug. There is a question in regard to the advisability of preanesthetic drugs in the cesarean section, for there should be no handicap to the respiratory efforts of the baby; and although many employ a barbitol or morphin and claim no disturbance, others report instances of a definite depressive effect upon the baby.

Apprehension attendant upon an operation demands more sedation. A patient who has previously experienced the effect of preanesthetic medication has a certain amount of anticipation with the second administration, and will be more resistant to the same amount of the drug.

An increased metabolic rate and fever—some-what similar factors, for they produce a more rapid absorption and elimination of any drug—demand a greater dosage. For example, in thyrotoxicosis the average dosage will produce inebriation rather than the desired drowsiness.

Choice of Medication

It is a known fact that the preliminary hypodermic of morphin, in the dosage of .015 to .01 gram (one-quarter to one-sixth grain) is of benefit; but there can be discussion as to the merits of pantopon, dilaudid, and scopolamin.

Pantopon supposedly depresses respiration less in relation to its narcotic activity, produces vomiting less readily, has less prolonged action, and is less euphoric than morphin. It has not proved to be as uniform in action and, as Barlow states, "it is not believed to have as *tranquilizing proper-*

ties as morphin." Collins of Chicago, on the other hand, is of the opinion that pantopon is a better drug than morphin. Personally, our experience is similar to that of Barlow.

Dilaudid, which is a quite commonly used drug in place of morphin, has an equal amount of narcotic effect, is excellent for routine use in relief of pain, but does not possess the desired preoperative hypnotic action.

Scopolamin (hyoscin) has no sedative effect, but does have an amnesic or disorientation phenomenon. It is this author's experience that, in the aged, this drug has been quite disturbing because of stimulation of unpleasant dreams and fearful memories. In children and adults it has a place, for it combines, with the above-mentioned effects, a depressant to the salivary and mucous secretions. Leech of Regina, Canada, recommends its use in small doses in addition to morphin, especially for children.

Tri-brom-ethyl alcohol (avertin) has a hypnotic, rather than an anesthetic effect, and it is recommended that it should be used only as a hypnotic in the production of "basal anesthesia." When used in too large a dosage, it carries with it the danger of losing the paramount factor demanded in anesthesia—the control of the patient. The demands made in the administration of this drug are comparatively great, and the period of postoperative recovery is prolonged, requiring increased nursing care. Supplemented with local anesthesia, this drug appears today to be the choice for brain surgery. In such cases, a long operation and special nursing care are the rule; but the operation, while meticulous, is not as shocking as the average celiotomy. In its favor are its complete elimination of psychic trauma, its lack of accompanying or subsequent nausea and vomiting, and its rare pulmonary sequelae. Against its use is the great potential danger to the safety of the patient in the loss of control by the attending physician or surgeon.

The *barbituric acid* hypnotics have demanded an increasing interest during the past fifteen years. There is a unanimity of opinion that oral or rectal administration is preferable and is sufficient, provided there can be an interval of three-fourths of an hour before operation. The intravenous method has too narrow a margin of safety. There is also confusion as to the best form of this drug because of the variation of hypnotic efficiency, the rate of oxidation and the speed of elimination which these barbituric acid combinations possess.

From the data available concerning some of the forms, the following facts have been determined:

Di-ethyl barbituric acid (barbital), 25 to 30 per cent, is used, is absorbed slowly, and 70 to 75 per cent is eliminated over seven to eight days.

Phenyl-ethyl-barbituric acid or phenobarbital (luminal) 80 per cent is used, is absorbed slowly, and the 20 per cent eliminated appears as late as the tenth day.

Allyl-iso-propyl barbituric acid (allonal) 80 per cent is used, is absorbed at a moderate rate, and all is eliminated by twenty-four hours.

Sodium iso-amyl-ethyl barbituric acid (sodium amytal) no definite data is available; but in comparison with phenobarbital, it is absorbed more rapidly, and has a greater and longer hypnotic effect, lasting up to ten hours.

Sodium ethyl-methyl-butyl barbituric acid or pentobarbital sodium (nembutal) no definite data is available, but in comparison with all other barbiturates it is rapidly absorbed, has a greater hypnotic and a less-prolonged effect, which is over, on the average, of four hours.

The more rapid the absorption the greater is the hypnosis, and the more rapid the elimination the quicker the recovery. Therefore, we can, with some scientific precision, choose the barbituric derivatives best adapted to the type of patient and operation. In order to assure the patient a restful night, preoperatively, sodium amytal or sodium pentobarbital are most universally satisfactory, since they are absorbed quite completely at a moderate rate and eliminated within eight to ten hours. For the immediate preoperative use, a rapidly absorbing form (greater hypnotic power) is advisable, and sodium pentobarbital (nembutal) is the choice. For prompt postoperative recovery a quickly eliminated form should be used, and we believe sodium pentobarbital (nembutal) gives the best results.

A most satisfactory hypnosis and prompt postoperative recovery are secured when sodium amytal is given the previous evening and, according to the patient's response, a dose of pentobarbital sodium is administered one and one-half hours before operation.

Personally, we believe the barbituric acid derivatives are the most practical and the safest drugs. For preanesthetic medication we employ sodium amytal .18 gram (grains iii) or pentobarbital sodium .09 gram (grain iss) orally the evening before operation, and pentobarbital sodium (nembutal) .09 gram (grain iss) one and one-half hours before surgery, with a hypodermic administration of morphin .01 gram (one-sixth grain) and atropin .004 (1/150 grain) one-half hour before surgery. Our experience has been similar to Barlow and his co-workers, who report that 68 per cent are drowsy and uninterested in any procedure, 24 per cent asleep, and 8 per cent inebriated and move slightly when disturbed. As previously stated, the aged do not stand barbitals well; yet, recently, pentobarbital sodium—possibly because of its relatively rapid absorption and elimination—has given us the desired effect without as much mental disturbance as with the use of other barbitals.

Conclusions

One's opinion, influenced by his experience, changes from year to year; therefore, the combined opinion of the profession on this problem is desired. It seems wise to select a combination of agents for complete elimination of psychic trauma, physical relaxation and freedom from pain, without depression of the patient's vital functions, but with control of the patient during the preanesthetic, anesthetic, and postanesthetic stages.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

EDWARD M. PALLETTE President
HOWARD MORROW.....President-Elect
W. W. ROBLEE.....Speaker
MORTON R. GIBBONS.....Council Chairman
FREDERICK C. WARNSHUIS Secretary-Treasurer

THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *American Medical Association Fellowship.*
2. *Who Knows Better?*
3. *Medical Legislation.*
4. *Legislation Flashes.*
5. *This Is the Law!*
6. *Endowments.*
7. *A Southern Trek.*

DEPARTMENT OF PUBLIC RELATIONS

1. *California Code Commission.*
2. *Automobile Versus Airplane Deaths.*
3. *San Mateo County Society Sets an Example.*
4. *Objectives of the California Heart Association.*
5. *Federal Resettlement Administration.*

ASSOCIATION ACTIVITIES

AMERICAN MEDICAL ASSOCIATION FELLOWSHIP

At the beginning of a new year it is timely to once more urge members to make application for fellowship in the American Medical Association. Our national organization performs a very tremendous amount of service for the profession as a whole as well as for every member. This service is related to national legislative matters and our relationship to the public and public activities related to health welfare and medical service.

There are twelve bureaus and councils with full-time directors or secretaries, located in the headquarters building in Chicago, and they, with the general officers and some seven hundred employees, are continuously and persistently engaged in work that concerns every doctor of medicine. Without that service our profession could not maintain the position and standing that we now hold. Without that service and alertness we would be the pawns of designing propagandists and those who are inspired by selfish and ulterior motives and quests. Our national association renders a very distinct and personal service to every doctor of medicine. It merits the support of every practitioner. That support is subscribed by becoming a Fellow of the American Medical Association. Are you rendering that support?

To become a Fellow you must make a special application through your State Secretary. Your membership in your county and state association does not carry or automatically convey to you American Medical Association Fellowship. Special application must be made as indicated above. Send in for an application blank today.

The annual fellowship dues are \$7. In return for these dues, you receive the benefits of representation and, in addition, the weekly issue of the *Journal of the American Medical Association*. Valuable as this journal has been, it is going to become more valuable by reason of a new department or section on medical economics that was added at the beginning of January. This new section will present information related to the Security program, federal legislation, and social movements—questions that are

receiving widespread attention in Washington and in every state.

Hence, the recommendation that you apply for fellowship and lend support to these activities that are so vital to your future.

WHO KNOWS BETTER?

An institution's medical director was conducting a few visitors through his sanitarium for mental cases. He paused before one patient, and asked: "John, why do you insist on scratching yourself?" "Because," the patient replied, "I'm the only person in the whole world who knows where I'm itching."

The medical profession alone knows what is best for the health needs of the public and what measures will sustain and provide adequate medical care on a quality basis consistent with scientific practices. While we know this to be true the public and legislators are not so minded, and as a result these lay groups and propagandists join with the politician in a nation-wide movement to create a new system for the providing of medical care and are ignorant of basic facts and conditions.

It is incumbent upon all of our members to educate these new deal proponents singly and collectively.

MEDICAL LEGISLATION

Elsewhere in this issue will be found the first "Legislature Flashes," transmitting information related to the bills that have been introduced in the present session of the legislature in so far as they relate to health and medical care. No attempt is made to dissect them or to indicate their apparent or hidden purposes. This will be done through other channels. These "Flashes" should indicate public and political trend. After all, the question of so-called state medicine, informed persons assert, will not be decided by the medical profession. The public will make the decision through its legislative representatives. Or rather, an organized minority of the public joining with an organized minority of politicians will write the ticket. That is the history of all new movements and new legislation.

The rôle played by medicine will be determined by how strong an organized group it can mobilize to shape, guide, and control the efforts and influence of the proponents for state-provided medical care. There rests the answer as to what medical legislation will be enacted during the next four or five months. Radical, ill advised, undesirable legislation to provide medical care under state or federal control can be defeated only by organizational influence and will depend upon the personal interest and work of every member. Therefore members should evidence constant interest in their county societies and unite in its representations.

LEGISLATURE FLASHES

On going to press (January 20) the "bill hoppers" of the legislature are crammed, the printing bureau is swamped, and the end is not discernible. The legislature adjourns January 22 for the customary thirty-day interval. More bills may then be introduced by general consent.

It has been impossible to obtain copies of bills relating to health and medical care because the printing department of the legislature is unable to keep up with the introduction barrage. Advance information gives the following as some of the bills that have been introduced:

Narcotic regulations.

Ten skeleton bills amending the Medical Practice Act.

X-ray Laboratory Bill.

*All articles listed under this caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

Farm Bureau County Hospital Bill.
 Medical Service and Hospital Bill (Senator Williams).
 Venereal disease control.
 Hospital Insurance Bill.
 Medical Care Insurance Bill.
 Dental Bill.

All these comprise legislation that directly affect medical care and practice. Our Committee on Public Policy and Legislation is intensely engaged in its work, and is giving most thoughtful attention to legislative matters.

It is well to remind members and county societies that no action for or against any legislative enactments should be registered until our committee or the Council outlines attitude and position. In due time and course a digest will be sent to every county society with instructions as to action. Await those instructions, but be prepared to respond when word reaches you through your county officers.

THIS IS THE LAW!

Eighteenth—The certificate issued herein for the practice of midwifery may be revoked for the failure to have the following equipment (in each case): Nail brush; wooden or bone nail cleaner; jar of green or soft castile soap; rubber gloves; tube of sterile vaseline; clinical thermometer; agate or glass douche reservoir; two rounded vaginal douche nozzles; two rectal nozzles, large and small; one soft rubber catheter; blunt scissors for cutting cord; either lysol, carbolic acid, or bichloride of mercury tablets; boric acid powder; one per cent solution of nitrate of silver; medicine dropper; narrow tape or soft twine for tying cord; absorbent cotton (preferably in one-quarter pound packages); no other instruments are to be used by a midwife. [Amended 1915, p. 184; amended 1917, p. 93; amended 1921, p. 1009; amended 1925, p. 281; amended 1927, p. 99; amended 1929, p. 626.]

Queries: Why agate or glass reservoirs? Why rounded tips? How does the fluid in the reservoir pass to the tips? As some member said: "A resident interne or nurse would be tossed out on their ear if they attempted to douche a woman in labor or after labor has terminated." Who had an overstock of quarter-pound packages of cotton?

Yes, this is the law of today! Surely, its framers of yesteryears (1927 and 1929) were meticulous in drafting an inventory for the midwives' obstetrical bag.

ENDOWMENTS

A doctor of another state, in providing for a \$50,000 endowment fund contribution to his state medical association, wrote:

"What I am endeavoring to do is to create an unending service to the medical profession and through them a better service to the sick. A man who serves only while he lives, serves only for a very short period. I would like for my services—existing in some form—to go on indefinitely after my physical being has ceased to exist."

What a noble thought and deed! We trust that those of our members who are able will emulate that ideal and purpose, and provide that their services may go on indefinitely in our Association.

A SOUTHERN TREK

At 5 p. m. on Tuesday, January 6, President Pallette and your Secretary set forth in an unusual rainstorm from Los Angeles for Santa Ana, where Councilor Emmons was met, to attend the regular meeting of the Orange County Medical Society. At 8 p. m., in spite of the rain, some one hundred members of the county society convened. Addresses were made by the State Association officers, and until 10:45 p. m. a general discussion, with questions and answers, dealt with national, state, and local problems that were related to medical care, practice, public health, and social-economic problems vital to our members.

Orange County members constitute one of our most active county units. They reflect in a most satisfactory way that which can be accomplished by unity of purpose and action. They are meeting in a most admirable way all of the medical and public-health questions that concern their community and are rendering a service that inspires public confidence.

By 12:30 a. m. we were in Los Angeles, and though the rain continued, its discomforts did not dampen the enthusiasm engendered by this county meeting.

On Wednesday your president and secretary went to Riverside, where they were met by Speaker Roblee and Councilor Emmons. At 8 p. m., 108 members of the Riverside and San Bernardino County Societies and ladies sat down to dinner in the Mission Inn. The postprandial program was opened by two vocal and harp selections by local artists, and fixed the harmonious theme of the subsequent addresses and discussions presided over by Speaker Roblee.

The members of these two constituent units also reflected the cohesive unity of our Association, and impressed the State officials with the fact that they are loyal to all of our ideals and policies.

At 9 a. m. on Thursday, January 7, President Pallette, Speaker Roblee, Councilor Emmons, and the State Secretary set forth for El Centro, in Imperial County. We skip the snow on orange trees and blossoming roses in Redlands and the hunger urges of the back-seat riders. These cries and pleas were silenced in the lunch room of the Barbara Worth Hotel in El Centro at 2 p. m. Following this a run was made into Mexicali, where in Mexican environment we meditated upon the very apparent difference in the living conditions and customs of the natives. The Speaker terminated the visit by speeding us back to El Centro to the tunes of guitar-strumming street urchins.

At 7 p. m. thirty-four members of the Imperial County Society convened for their monthly meeting. A fine group of men and a 100 per cent society, having all eligible physicians as members. Their treasury has a sufficient balance to pay the 1937 State dues, so no assessment is being made on the members for this year.

On Friday morning, through icy roads, and snow, strange as that does seem, we began our return trip, leaving Doctors Roblee and Emmons at Riverside, and President Pallette was left in Los Angeles in time for late afternoon office hours. Your Secretary continued on to Santa Barbara.

On Saturday, January 9, the Scientific Program Committee and the officers of all scientific sections met for the purpose of reviewing and approving the program for the Del Monte meeting. Suffice it to state at this time that the 1937 scientific program will be most attractive and will impel a large attendance. Detailed announcements will appear in subsequent issues. Sunday, January 10, return drive was made to San Francisco.

Would that every member could visit all of our county units. He would become deeply impressed with these fellow members. He would gain a pride and feel an increased appreciation for his organizational affiliation.

COUNCIL MINUTES

Minutes of the Two Hundred and Forty-Ninth Meeting of the Council of the California Medical Association

Pursuant to the call of the Chairman, the Council of the California Medical Association convened in special session in the Sir Francis Drake Hotel, San Francisco, on Saturday, January 16, 1937, at 9:30 a. m.

1. **Roll Call.**—The meeting was called to order by the Chairman, with the following members present:

President Edward M. Pallette, Speaker William W. Roblee, Chairman Morton R. Gibbons, Councilors Karl L. Schaupp, Calvert L. Emmons, Carl R. Howson, Henry J. Ullmann, Axel E. Anderson, Alfred L. Phillips, C. E. Schoff, Henry S. Rogers, William H. Kiger, J. B. Harris, C. O. Tammer, T. Henshaw Kelly; Chairman of Public Relations Committee Charles A. Dukes, Editor George H. Kress, Secretary F. C. Warnshuis, General Counsel Hartley F. Peart and his associate, Howard Hassard. Mr. Lionel Browne was present during the discussion of the report of the Committee of Five. Honorable Walter McGovern and Honorable Melvin I. Cronin addressed the Council.

Absent: President-Elect Morrow (on account of illness) and Councilors Hamlin and Wilson.

2. **Scientific Committee Report.**—A report of the meeting of the Committee on Scientific Work, held on January 9 at Santa Barbara, was given by the Secretary.

It was moved by President Pallette, seconded by Councilor Rogers, that, in accordance with the recommendation of the Committee on Scientific Work, the third general meeting be devoted to a discussion of health and hospital insurance. Carried.

3. Papers for Publication in Journal.—After discussion of the advisability of publication of a paper submitted for publication in the JOURNAL, it was moved by President Pallette, seconded by Councilor Rogers, that the paper as presented be published. Carried.

After consideration of the paper "Practice of Medical Problems in Hospitals," the Council agreed that there would be no objection to its publication in the JOURNAL under the names of the authors.

4. Exchanges.—Members in the southern part of the State, in an endeavor to build up the Reference Library of the Los Angeles County Medical Association, requested the Council to give consideration to obtaining two exchange copies of medical journals.

It was moved by Editor Kress, seconded by Speaker Roblee, that editors of state medical journals be requested to grant duplicate copies of their journal in exchange for two copies of CALIFORNIA AND WESTERN MEDICINE, one copy of the exchange journals to be sent to the San Francisco County Medical Society Library and one copy to be sent to the Los Angeles County Medical Association Library. Carried.

5. California Medical Economic Survey.—Deputy Attorney-General Lionel H. Browne, representing the State Board of Health, cosponsors of the California Medical Economic Survey, gave a résumé of the terms and conditions under which the survey had been conducted and the responsibilities of the State Board of Health and the California Medical Association. Deputy Attorney-General Browne read the resolutions relating to the survey adopted by the Board of Health at a special meeting thereof.

It was moved by Chairman of Public Relations Committee Dukes, seconded by Councilor Rogers, that the Council of the California Medical Association approve the resolutions adopted by the State Board of Health. Carried.

6. Legislation.—Junius B. Harris, Chairman of the Committee on Public Policy and Legislation, gave a résumé of the present legislative activities and informed the Council of the committees appointed by the Senate and Assembly having to do with public health and medical practice.

The Secretary presented correspondence from Doctor Russel V. Lee of Palo Alto, together with proposed law for the control of venereal diseases. After full discussion, on motion of Editor Kress, seconded by Councilor Kiger, the following resolution was adopted:

WHEREAS, The federal, state, and local public health agencies have authorized and are putting into operation carefully prepared plans for a campaign for the prevention and treatment of syphilis and gonorrhea; and

WHEREAS, The utilization of federal funds in this work necessitates centralization of state procedures in and through the California State Board of Health; now therefore be it

Resolved, By the Council of the California Medical Association that it is in full sympathy with all rational and practical efforts to solve the problem of syphilis and gonorrhea; and be it further

Resolved, That this Council suggests that all groups and citizens who wish to cooperate in the work, do so in conjunction with the State Board of Health.

It was moved by Councilor Kelly, seconded by Councilor Ullmann, that the Council commend the San Francisco *Daily News* for its attitude toward the present campaign and publication of articles dealing with venereal diseases. Carried.

It was the consensus of opinion that the Code Commission's revision of the medical practice laws should be handled by the Secretary of the Board of Medical Examiners.

7. Legal Counsel.—The General Counsel reported on the complaint filed by a taxpayer in Kern County against the Board of Supervisors regarding the building of a branch hospital at Delano; and contempt proceedings about to be filed against the Supervisors for violation of the injunction in the case of *Goodall vs. Brite*. Mr. Peart

also reported on proposed amendments to the county hospital bill, definition of indigency, amendments on county hospital legislation.

8. Public Health and Welfare.—The Secretary presented correspondence from the American Medical Association and resolution from the Illinois State Medical Society regarding the United States Public Health Service. No action was taken pending the establishment of policies by the American Medical Association, and the entire matter was referred to the Executive Committee.

President Pallette called to the attention of the Council two statements which will appear in the January 16 issue of the *Journal of the American Medical Association* regarding health welfare and cooperation with State and local agencies. The formulation of a policy was referred to the Executive Committee.

9. Hospital Insurance.—Discussion was had of the extension of the Intercoast Hospitalization Association and the rider attached to the policy of that Association.

It was moved by President Pallette, seconded by Speaker Roblee, that the entire matter of the Intercoast Hospitalization Association be referred to the next meeting of the Council and that in the meantime the Secretary and the Chairman of the Executive Committee contact the president and other officers of the Intercoast Hospitalization Insurance Association and secure definite information. Carried.

10. Retired Memberships.—In accordance with provisions of the by-laws, the Secretary presented retired membership data signed by the respective county medical societies.

It was moved by Councilor Schaupp, seconded by Councilor Ullmann, that Charles D. Ball, M. D., member of the Orange County Medical Society, be granted retired membership in the California Medical Association. Carried.

It was moved by President Pallette, seconded by Speaker Roblee, that Charles G. Levison, M. D., member of the San Francisco County Medical Society, be granted retired membership in the California Medical Association. Carried.

It was moved by Chairman of Public Relations Committee Dukes, seconded by Councilor Schaupp, that Cullen F. Welty, M. D., member of the San Francisco County Medical Society, be granted retired membership in the California Medical Association. Carried.

11. Noon Recess.—At this point a recess was taken for luncheon with the Legislative Committee of the two State Dental Associations.

12. Call to Order.—The meeting was called to order after the noon recess, with the following members present: Doctors Pallette, Roblee, Gibbons, Schaupp, Emmons, Howson, Ullmann, Anderson, Phillips, Schoff, Rogers, Kiger, Harris, Tanner, Kelly, Dukes, Kress, Warnshuis, and Mr. Peart and Mr. Hassard.

13. Hospital and/or Medical Insurance.—T. Henshaw Kelly, Chairman of the Committee on Hospital and/or Medical Insurance, presented the proposed act covering medical service association for discussion by the Council. The bill was considered section by section and certain amendments made.

It was moved by Chairman of Public Relations Committee Dukes, seconded by Councilor Rogers, that the bill as amended be approved and that the Legislative Committee proceed to have it introduced forthwith.

A roll call vote was then taken and the motion was unanimously adopted.

Doctor Harris called the attention of the Council to the medical service bill introduced at the present session of the Legislature by Senator Dan Williams. It was the sense of the Council that this bill should be discussed at the Annual Conference of County Secretaries.

William H. Kiger, member of the Special Committee on Hospital Service Insurance, outlined the activities of the hospitals in the southern part of California and asked Doctor Kress to read the bill to govern hospital insurance as proposed by the southern hospitals.

The bill was read and discussed, and on motion of Councilor Schaupp, seconded by Councilor Phillips, the bill on hospital insurance as presented was approved, and Doctor Kiger was authorized to arrange for its introduction at his discretion. Carried.

14. **X-Ray Legislation.**—The x-ray bill as presented by the Pacific Roentgen Club was referred to the Legislative Committee for report at the February 7 meeting of the Council. Carried.

15. **Adjournment.**—There being no further business to come before the Council, adjournment was taken at 5:50 p. m.

MORTON R. GIBBONS, *Chairman*.
F. C. WARNSHUIS, *Secretary*.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

California Code Commission: Recodification of the Medical Practice Laws

A former legislature created a Code Commission for the purpose of rewriting and codifying existent laws.

When one reads some of the laws as they were drafted and passed, wonderment grows as to verbiage, verbosity, and interpretation. Why confusion results is easy to explain. Why attorneys, and even courts, arrive at differing conclusions is not hard to understand. But what else could be expected in view of the process that governs legislation procedure. To correct these errors, to clarify meaning and to correct errors in grammar, this Code Commission was created.

The Code Commission has been engaged in its task for several months. It has been very considerate in inviting interested groups to review its redrafts. After it had rewritten the medical practice law the Commission invited our Association to confer with a representative of the Commission and give advice and express opinion in order that the original intent and meaning of each section might not be altered.

The Council appointed a special committee, as did also the Board of Medical Examiners. These two committees and a representative of the Commission met and spent some twenty hours in checking every line and word of the redraft with the original law and completed the revision of this law. It is believed that it is now in a form that will be readily understood and interpreted. There was no authority to make any changes in basic provisions or intent or to include any amendments. Clarification was the sole objective. Verbosity was eliminated and grammatical construction was improved.

The Legislature will now approve this redraft, thereby placing in our statute code a well-constructed law. The following members rendered this service: Doctors J. B. Harris, M. R. Gibbons, Sr., Howard Morrow, T. Henshaw Kelly, State Secretary, Mr. Hartley Peart and his associate, Howard Hassard, for the Association, and Doctors C. E. Schoff, C. L. Abbott, C. B. Pinkham, and Mr. Lionel Browne for the Board of Medical Examiners.

Automobile Versus Airplane Deaths

An airliner with twelve passengers crashed and twelve deaths result. Extra newspapers, radio bulletins, three investigations, and congressmen gaining publicity through promises of introducing bills to create other investigations and useless laws. Papers blazing with many point-size headlines dealing with this unfortunate "crash," in a sixth or seventh page column item in small type report 1,061 deaths on the streets in one city caused by automobiles. Yet no comment follows on this slaughter on streets and highways.

Airplane travel is safe. It is safe from a mechanical standpoint because these plane accidents do not result from mechanical or plane failure. Plane travel is safe from the physical fitness of pilots' standpoint because

competent medical advisers and examiners have formulated physical standards for pilots. Airplane travel has a danger factor from an operating standpoint because operating officials are neglecting two important factors—judgment failure and weather conditions.

Judgment failure or man failure looms up when dispatchers and pilots ignore the elements, think they can ride through and delay in making emergency landings, or issuing grounding orders. Judgment man failure also occurs when the pilot runs into a blind spot, loses his course and bearings and continues to fly on at an altitude that is lower than the highest ranges on his course. Pilots should be drilled and drilled so that they know the peak altitudes of their terrain and be schooled and schooled that in emergencies or when encountering visibility that is nil that they shall immediately commence climbing to an altitude at least 1,500 feet higher than the highest peak on their course or terrain and maintain that altitude until they regain their bearing and necessary visibility. Observance of this rule will prevent crashes into sides of mountains. Storms and adverse flying conditions are reported on every course. The alert pilot should have courage to turn back or ground rather than to take a chance on riding through. If he does not, the operating dispatcher ought to exercise his authority and either issue orders to turn back or ground the plane in a safe emergency landing field. We have commended one pilot for taking us back and another for making an emergency landing even though we were grounded for four hours. Airplane travel is safe and will be safer when operating officials observe these two emergency rules.

As to the slaughter by automobiles, that will continue until legislators ignore the political pressure and influence of manufacturers and dealers and enact new laws governing automobile driving. What is needed is a law fixing standards of physical fitness that must be met to obtain a driver's license. A paper reporting a plane accident had an item imparting that an automobile driver was receiving a blind man's pension each month. Think of it!—vision so poor as to qualify for a blind person's pension, yet given a license and permitted to drive an automobile!

Another law or amendment is required to give police and patrol officers authority to revoke drivers' licenses of all who violate traffic laws. Leniency has generated disdain for traffic laws and encouraged violations.

Some day public opinion may overcome the mercenary policies of automobile manufacturers and dealers and bring about legislation and enforcement.

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SAFER IN AIR THAN ON HIGHWAYS

When one considers that the Sunday night accident to a United Air Lines plane, near Saugus, was the first serious crash in eleven years of the company's operations between San Francisco and Los Angeles, the tragedy is softened somewhat; and the growth of the flying habit among Americans is explained. Over the Coast route, this line has made 20,000 flights, totaling 7,000,000 miles, without a mishap to passengers, in multimotored planes, until this exception occurred.

On the same day, twelve lives were lost in highway traffic in Los Angeles County, with a total of more than one thousand victims for the year.

Thorough investigation was made of the air disaster, and every known remedy will be applied to prevent repetition. If the same degree of preparation and care should be directed to the prevention of motor-car accidents, better progress would be made toward safety on streets and roads.

Perhaps, after all, the greatest factor in continuing the terrific traffic toll is public apathy due to the average individual's smug belief that motoring may be dangerous for other persons, but not for him.—*Long Beach Press-Telegram*.

San Mateo County Society Sets an Example

The following communication reflects a commendable example for all of our county societies. Such contacts with boards of supervisors is bound to be productive of good, better understanding, and mutual satisfaction. Every county medical society should make similar contacts with their supervisors and legislators. We congratulate and

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

commend the members of San Mateo County in this well-directed activity. They are discharging a county society function that is quite important.

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SAN MATEO COUNTY MEDICAL SOCIETY

December 31, 1936.

To the Honorable Board of Supervisors of San Mateo County, Redwood City, California.

Gentlemen:

Since the recent election there has been a feeling on the part of the members of the San Mateo County Medical Society that our organization should communicate with you gentlemen to transmit our ideas in regard to the County Department of Health and Welfare. Informal discussion with some of your board confirmed our feeling that you might like to hear from us and have our Society form a standing committee which would be ready at any time to cooperate with your board.

It is our opinion that you gentlemen, constituting as you do the first Board of Supervisors elected at large according to the provisions of the county charter, are going to stand for improved governmental conditions in our county. As citizens of the county we, too, want good government, and as physicians who helped to formulate the health and welfare provisions of the charter, we feel vitally interested in these provisions.

As a body of medical men and women who are in almost constant intimate contact with public health and welfare matters, we respectfully submit the following suggestions which we hope will prove of value when the health and welfare provisions of the charter are under consideration by your board. We should like to have it understood at the outset that it is not our desire to criticize anything that has been done in the past. We offer these suggestions exactly as they might have been offered when the charter first went into effect.

The administrative head of the county government is a highly important official whose appointment is entirely in the hands of your board. Under his jurisdiction the county executive has, among other departments, the Department of Health and Welfare, and its efficient operation is dependent upon his administrative ability. The charter calls for the appointment by the executive of an advisory board of health and welfare, whose duties primarily are to aid the executive in selecting a director of public health and welfare, to advise with the executive, the director, and the various department heads in this division. The functions of this board are of great importance, and a good executive will select such a board with careful consideration and, having selected it, will make frequent use of it and discuss freely with its members the policies and operations of the department.

We feel that the position of director of public health and welfare should be filled by a physician who is sufficiently mature in years to have gained experience in dealing with people, that he should have executive ability, that he should be a man who meets with the approval of the physicians of the county, and that he should have some special training and experience in this type of work. The modern trend in medicine is to attempt to have every physician consider himself a volunteer health officer, and to have him working hand in hand with the Public Health Department. It follows that no public health director can efficiently run his department without close cooperation on the part of the physicians in his community.

An important position under the Department of Health and Welfare is that of superintendent of the county hospital. Again it is necessary to have a man who enjoys the confidence of the medical profession. Most of the medical and surgical service at the hospital is rendered gratis by the doctors of the community, which, we feel, results in standards of service higher than they would be if physicians were employed to do the work. Furthermore, this service, if paid for by the county, even at minimum rates, would be a tremendous burden to the taxpayer. Further requisites of the hospital superintendent are that he should be a competent medical man and should possess executive ability. He should run the hospital as economically as possible in keeping with good hospital care.

The Department of Social Service is responsible for the admission of patients to charity service in the hospital and clinics, and for the care of the poor, the blind, etc., in the home. It is not an uncommon practice on the part of certain people to attempt to get free hospital and medical care at the expense of the county even though they could, by no stretch of the imagination, be called indigent. This is an unfair burden on the respectable citizen, who pays taxes to maintain these institutions and who at the same time must provide for his own care and for that of

his family in case of accident or illness. It is also unfair to the doctors who contribute their time and skill in an effort to provide proper care for those who are supposed to be indigent. It is probable that every county in the State of California has at some time, in the course of its history, had county officials who made a practice of repaying political favors by influencing the Social Service Department in such manner that the department would make possible the admission of non-indigents to the county hospital. Obviously, the taxpayer and the doctor pay the bill. Another practice, unfortunately only too common, has been the appointment of political favorites to the positions of investigators in the department. It is the feeling of the County Medical Society that such policies are not consistent with good county government.

The superintendent of social service should be a person who has had wide training and experience in the work. He or she should possess real business ability, and at the same time have enough humanitarianism to treat decently those who are really in need. The superintendent should be free of all political pressure, should be able to appoint his own workers, and should be directly answerable to the director of health for his results.

Referring again to the Department of Public Health, we would like to suggest that a concerted effort be made to bring all of the people of the county under this department by inducing the cities to abolish their local departments and to contract their health work to the county. The county department serves only a relatively small fraction of the population, a condition not consistent with economical administration. If the various city officials have confidence in the County Department of Public Health, they should be glad to eliminate their local departments. We feel that you gentlemen have a unique opportunity to restore confidence in the government of our county and so make possible for unification of public health work under one head, the Director of Public Health and Welfare.

In summary, we feel that we have at present a Board of Supervisors, composed of men of sound business sense. In the administration of county government it is our opinion that where competent executives are placed at the head of the several departments, it is unnecessary for the Board of Supervisors to feel called upon to dictate the policies of, and make appointments in, these departments, maintaining, of course, its power of veto. It would seem that unnecessary confusion would be eliminated and adverse publicity avoided if the board felt sufficient confidence in its department heads to refer the complaints of constituents to the department involved. We feel sure that you gentlemen will agree with us when we say that political patronage is not consistent with good county government.

In this communication our motive has been to lend helpful suggestions. As physicians and fellow taxpayers we are interested, on the one hand, in the efficient operation of our County Health Department and all of its branches, and on the other hand, in the economically sound administration of county government. It is with the hope that we may cooperate with the Board of Supervisors toward these ends that this communication is respectfully submitted.

Very truly yours,

THE SAN MATEO COUNTY MEDICAL SOCIETY.

Objectives of the California Heart Association

The aim of the California Heart Association shall be the better education of both the medical profession and the general public in heart disease and its resultant disability:

Medical Activities

1. Arrange for diagnostic clinics and postgraduate education work in rural areas.
2. Seek representation of cardiac problems on programs of local county medical association meetings.
3. Sponsor two major yearly symposia on heart disease, one in San Francisco and one in Los Angeles.
4. Provide some method by which physicians may obtain postgraduate consultation on individual problems within the limitations of the standards of the American Medical Association and where direct consultation service is not available.
5. Foster a wide membership in state and national heart associations.
6. To accumulate and have available for all physicians in the State the latest proved methods for the handling of cardiac disease.
7. To promote uniform criteria for diagnosis and records among the general profession.
8. To study the etiology of cardiac and circulatory disease by accumulation of data and to act as an authorita-

tive source in dispensing proved scientific knowledge in this field.

9. To foster and guide worth while research in the field of cardiovascular disease.

Public Relation Activities

1. To coöperate with public health departments, school health departments, social and health agencies, and other organized groups in all constructive efforts to present information tending to aid in the cure and prevention of heart disease.

2. To coöperate with industrial and insurance companies relative to the employment, hazards, and liability of persons with circulatory defects.

3. To prepare educational exhibits for presentation to the public.

4. To present approved heart educational material to the general public by means of newspaper releases, radio programs, moving-picture films, news letters, and pamphlets.

General Activities

1. To combat misinformation about heart disease and make every attempt to combat quackery.

2. To consider the provisions made for convalescent cases, not ill enough to require hospital care, but not well enough to work and to foster a rehabilitation program.

3. To attempt to arrange a proper evaluation of the status of the heart in industry and employment.

4. To attempt to arrange the proper evaluation of the insurability of heart disease.

5. To properly evaluate the natural resources of California as applied to the treatment, the care, and the residence of those people afflicted with heart disease, and those other people from other localities who select this state as their place of residence.

6. To investigate and promote all proved methods for the institution of preventive measures in heart and circulatory disease.

Federal Resettlement Administration

This federal agency was formed to grant aid to farmers in drought-stricken areas. The Administration purposes to aid agriculturists to rehabilitate their farms or gain a new location for their agricultural labors. Clients of this Administration are the recipients of loans from the Government.

In the course of its activities this Resettlement Administration has prepared articles of incorporation and by-laws under which, by coöperative methods, the clients can organize for the purpose of providing medical care for themselves and their dependents. Such a corporation has been formed in North Dakota. Now the information at hand indicates that the forming of a similar corporation is contemplated by Mrs. R. B. Maycock, Chief of Home Management Section, and Mr. D. G. Hildebrand, Supervisor of Los Angeles County, and that they have "set out to find some hospital group or clinic that will undertake to provide medical service for clients of the Administration in Los Angeles County.

The articles of incorporation provide, among other things:

To associate its members together for their mutual benefit and to further the rehabilitation of said members and to that end to engage in any activity involving or relating to the obtaining for its members of medical and dental treatment and services and any surgery, nursing or hospitalization, necessary or convenient thereto.

... and to make provision for the payment of and pay bills rendered to its members by physicians and dentists. . . .

In North Dakota, physicians are asked to render these services for a fixed fee, and physicians unwilling to coöperate are being listed as "ineligible"—black-listed.

Here, then, is found another plan of bargaining for medical care for federal clients under terms and conditions prescribed by the lay group. At present no approach has been made to accredited representatives of our profession. Probably the "ticket" will be written and then the members of the profession will be asked to underwrite it. How long will it be ere federal and state representatives will learn the wisdom of first consulting with medical representatives before they formulate their plans and procedures for providing medical care?

COMPONENT COUNTY MEDICAL SOCIETIES

SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Frank MacDonald, on November 17, 1936, at the Auditorium on Twenty-ninth and L streets. Some seventy-two members and guests were present.

The paper of the evening was given by Dr. W. W. Cross of Oakland, on *A Review of Four Hundred and Seventy Cases of Pyelonephritis*. The speaker stated this disease may occur from the ages of three to seventy-six, and is three times more common in females than males. The commonest organism found, in the order of their frequency, are colon bacilli, staphylococcus, and streptococcus. Pyelonephritis usually occurs in the course of a general infection, so the primary focus must be sought elsewhere. The bacteria may be carried to the kidneys in three ways—by the blood stream, through the lymphatics, or ascending from mucous membranes lower down the tract. Ptosis, strictures, and obstructions of other types may serve as exciting causes through interference with proper urinary drainage. Microphotographs, beautiful because of the manner in which the stains brought out the details, were shown, comparing normal and pathologic structures.

The paper was discussed by Doctors Hale and Beach, who, together with Doctor Isoard, thanked the speaker for his splendid presentation of the subject.

The report of the Board of Directors was read. Doctor MacDonald stated lodge practice violated at least five of the Principles of Medical Ethics as applied to contract practice, and presented the following resolution from the Board of Directors for action by the Society:

WHEREAS, Certain lodges, orders, and fraternal organizations provide medical services as an inducement to membership in these organizations and

WHEREAS, In the opinion of the Board of Directors of the Sacramento Society for Medical Improvement, the sale of such medical services through contracts with private physicians constitutes the practice of medicine; therefore be it

Resolved, That such practice of medicine by lodges, orders, and fraternal organizations be disapproved by the Board of Directors of the Sacramento Society for Medical Improvement; and be it further

Resolved, That the above resolution shall become effective only if it is endorsed by the majority of individual members at the next regular meeting of the Sacramento Society for Medical Improvement.

Doctor Reardan moved that the resolution be laid on the table. Seconded by Doctor Vance.

Discussion:

Doctor Teall asked, "Is this an ethical question or one of political politics? Will the Code of Ethics apply equally to violations by old-established men as well as by newer members of the Society?" He asked for a definite policy to guide the younger men.

Doctor Dozier asked for instructions as to how the Board of Directors should act in prosecuting violations of the Code of Medical Ethics.

Doctor Hale: This is an old and moot question which has been inherited from the past. This type of practice is unethical, but since we are divided on it, it should be laid on the table. If someone resigns, before night another doctor may seek the appointment or else an osteopath with an M. D. degree will take it or else new doctors may come in and take it. I recommend a gradual process to prevent new evils and in time to correct the old even as in correcting the county hospital situation here.

Doctor Lawson: I ask for consistency. We have disapproved the Mutual Benefit Health and Accident Association and approved the Intercoast Hospitalization Insurance Association. There is no justice in acting definitely regarding certain orders and tabling action against others in the same category.

Doctor Isoard: On account of agitation for State medicine, let the problem of lodge practice be undisturbed.

Doctor Reardan: A new member, in the past, once tried to gain admission to the Society, so he resigned his lodge connections and immediately a member of the Society took over the work.

Doctor Schoff: The Board of Directors have been zealous in enforcing the Code of Medical Ethics, for which they should be complimented. Harmony should prevail now because the action of the Sacramento Society for Medical Improvement, at the last meeting of the State Legislature, was chiefly responsible for defeating Senate Bill No. 454.

Upon putting the motion to a vote to table the matter, it carried—42 to 14.

The report of the delegates to the State meeting, by Doctor Hale, stated the delegation showed a definite trend to the right in dealing with economic problems and by their voting. State dues were fixed at \$15 by the House of Delegates.

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The annual business meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Frank MacDonald, on December 15, 1936, at the Auditorium on Twenty-ninth and L streets. Thirty-seven members were present.

The financial and membership report of the secretary was read. A motion was made, and seconded, that the dues be \$20 for 1937. The motion was lost. A motion was made, and seconded, that dues be \$15; also was lost. A motion was made, and seconded, that the dues for 1937 be \$17.50. The motion was passed.

The following were elected as members on the Board of Directors for 1937: Wallerius, Schluter, Van Den Berg, Cook, Dozier, Ankele, Kanner, Christman, and Fanning.

Doctor MacDonald was unanimously elected to serve as delegate with Doctors Hale and Scatena for 1937. Doctor Pollock was elected to serve as alternate with Doctors Cook and Christman for 1937.

Dr. Glenn E. Millar was nominated and elected secretary-treasurer of the Sacramento Society for Medical Improvement.

NORRIS R. JONES, *Secretary*.

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PLACER-NEVADA-EL DORADO-SIERRA COUNTIES

The Placer County Medical Society met at the Freeman Hotel Saturday evening, January 9. The meeting was called to order by President C. E. Lewis at 8:15 o'clock. In addition to President Lewis, there were present the following members and visitors:

Members—Doctors E. E. Lundegaard, L. B. Barnes, Daniel L. Hirsch, Robert A. Peers, Ray C. Atkinson, Mildred E. Thoren, Max Dunievitz, W. A. Vinks, D. M. Kindopp, and C. C. Briner.

Visitors—Mr. W. F. Higby of San Francisco, executive secretary of the California Tuberculosis Association, and Miss Lu Crandall of Auburn, Public Health nurse.

This being a meeting devoted to the subject of tuberculosis control, the secretary, at the request of President Lewis, gave a short address on the essentials in the control of tuberculosis and discussed the proposed plan of the Placer County Tuberculosis Association's campaign for tuberculin-testing school children of Placer County.

The secretary introduced Mr. W. F. Higby, who gave a history of the antituberculosis movement in California since 1904 to date, outlining the various steps taken by the California Tuberculosis Association between these dates. Mr. Higby stated that it is the policy of the California Tuberculosis Association to work in cooperation with the various county medical societies. He outlined the tuberculin-testing programs which are being carried on in forty counties in California, always in cooperation with Organized Medicine.

Following Mr. Higby's address, a resolution of endorsement of the tuberculin-testing program of the Placer County Tuberculosis Association was adopted.

Doctors Atkinson and Briner exhibited a moving-picture film relating to childhood tuberculosis and tuberculin-testing.

The meeting then adjourned for refreshments.

ROBERT A. PEERS, *Secretary*.

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SAN BERNARDINO COUNTY

The meeting of the San Bernardino County Medical Society was held at the San Bernardino County Charity Hospital on Tuesday, December 1, 1936.

The meeting was called to order by the president at 8:15 p. m. About sixty members and guests were present.

A letter from Doctor Card was read and details regarding the joint meeting with the Riverside County Society on January 6 explained. The joint meeting for the officers of the California Medical Association will replace the regular meeting in January.

The program of the evening was given as a medical clinic by Dr. Phillip A. Corr of Riverside.

The following cases were presented and a short differential diagnosis given, preparatory to detailed discussion of treatment by Doctor Corr:

Diabetes Mellitus. Simple office management was stressed and protamine-insulin briefly discussed.

Pernicious Anemia. Various preparations used; cost and potency compared.

Pellagra. This case formed the basis of an excellent discussion of vitamins in general.

The cases were discussed by Dr. G. S. Landon of San Bernardino, Dr. Harold Gentry of Redlands, Dr. J. W. Neighbor of Arrowhead Springs, and was followed by a most enthusiastic and stimulating general discussion.

The meeting adjourned at 10:20 p. m., following which refreshments were served.

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SAN MATEO COUNTY

The San Mateo County Medical Society met on December 23, 1936, in the banquet room of the Benjamin Franklin Hotel.

The guest speaker of the evening, Dr. Stanley Mentzer, presented a most illuminating discussion on the most recent advance in the diagnosis of gall-bladder disease, involving a new concept—obstructive cholecystitis. Doctor Mentzer's talk was illustrated with lantern slides, and was discussed by Dr. Carl Hoag and Dr. James Rinehart.

The secretary read a resolution pertaining to the attitude of the San Mateo County Medical Society concerning the corporate practice of medicine. A motion was made and seconded that the resolution be adopted in its entirety and was passed unanimously.

Dr. William Murphy read a letter that had been prepared by the Committee on County Affairs to be delivered to the Board of Supervisors of San Mateo County. Following the reading of the letter, a motion was made and seconded that the committee be empowered to submit the letter to the Board of Supervisors, with the approval of the San Mateo County Medical Society. This motion was passed unanimously.

Doctor Wade Macomber read a letter he had received from the United States Government concerning examination, vaccination, and typhoid inoculation of members of the Civilians' Military Training Camp, such medical service to be contributed by the physician. Dr. Frank Holmes Smith felt that the Civilians' Military Training Camp was a worthy cause, and agreed to take over the work for San Mateo County.

The chairman made an announcement concerning the nurses' fund for Mills Hospital and the San Mateo Community Hospital, following which a collection was taken. The collection amounted to \$40, and the secretary was directed to withdraw \$10 from the treasury as an additional contribution.

The secretary read a letter he had received from Dr. H. Henderson concerning her work in Daly City in regard to immunization and vaccination of school children. Following open discussion, the secretary was directed to write to Doctor Henderson, stating the facts in the case.

Dr. William Murphy, chairman of the Committee on Vaccination and Immunization of School Children, gave a report. The motion was seconded and carried to accept the report as read.

Dr. Carl Hoag, chairman of the Committee on Hospital Service Insurance, gave a report from his committee. The report was approved with recommendations concerning the policy of the San Mateo County Medical Society in connection with hospital service insurance in the coming year. Dr. Harold Hill made a motion that the committee continue to function and report to the Society as progress is made in the development of hospital insurance in the Bay counties. The motion was seconded, and carried.

A report was heard from Dr. William Knorp, chairman of the Public Health Committee. Doctor Knorp mentioned particularly the work that has been done and the program outlined by the San Mateo County Tuberculosis and Health Association. On motion, unanimously passed, the report was accepted.

The election of officers resulted as follows: Frank Gregory, president; Hartzell Ray, vice-president; J. Garwood Bridgman, secretary. Board of Directors—Olin M. Holmes, William Murphy, William Knorp, Erma Macomber, N. D. Morrison, Frank Gregory, and J. Garwood Bridgman. J. GARWOOD BRIDGMAN, *Secretary*.

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SANTA BARBARA COUNTY

The annual banquet meeting of the Santa Barbara County Medical Society was held at the El Paseo on Monday evening, January 11. Fifty-seven members and five guests were present.

At the conclusion of the dinner, Dr. P. A. Gray announced the results of the election of officers for the year: Irving Wills of Santa Barbara, president; Edward Lamb of Santa Barbara, president-elect; A. L. Mollath and Albert Missall, both of Santa Maria, vice-presidents-at-large; William H. Eaton of Santa Barbara, secretary-treasurer. Council—Hugh Freidell and H. E. Henderson, both of Santa Barbara, and O. C. Jones of Santa Maria.

Amendments to the Society's by-laws were given their last reading, and were unanimously adopted.

Amendments to the Society's constitution were given their second reading, and were ordered held for their final reading and adoption at the February meeting.

Retiring President Gray reviewed briefly the work of the Council for the past year, complimenting the members upon their accomplishments; and he also expressed his appreciation and thanks to the members of the various committees for their splendid coöperation and services. He then introduced Dr. Irving Wills, the newly elected president.

Following a few introductory remarks, President Wills introduced the speaker of the evening, Dr. Alice Solomon of Berlin, Germany. Doctor Solomon's life work has been social service, and she gave an extremely interesting and instructive talk upon the social service work in France, England, and Germany, commenting on comparisons, and stressing the importance of this work in the future development of the human race. At the conclusion of the talk she answered pertinent questions, which brought to an end a very enjoyable evening.

WILLIAM H. EATON, *Secretary*.

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TULARE COUNTY

The regular December meeting of the Tulare County Medical Society was held, by invitation, with the Tulare-Kings Dental Association. A dinner at Motley's Café preceded the joint meeting.

The guest speaker of the evening was Dr. Herman Becks of the University of California. He presented the subject of *Bone Pathology or Biology in Relation to Dental Medicine*, profusely illustrating the talk with lantern slides and also showing a set of typical x-ray reproductions that are being used as a basis for diagnostic comparisons. KARL F. WEISS, *Secretary*.

CHANGES IN MEMBERSHIP

New Members (18)

Alameda County.—Philip N. Baxter, Chelsea D. Eaton, George E. Koerber, Robert F. Legge, E. B. Leland, Floyd D. Lewis, Camille Mermod, Kenneth A. Nielson, William Henry Probert, Robert L. Redfield, Amy N. Stannard.

San Bernardino County.—Kenneth Harvey Abbott, Francis L. Crowley, Emmett Forde Kesling.

San Francisco County.—Reuben Herman Zumwalt.

San Joaquin County.—John T. Heavey.

Santa Cruz County.—Gordon Bunney, William Lawrence Young.

Transferred (1)

Leslie J. Seeley, from Siskiyou County to Shasta County.

In Memoriam

Green, Louis David. Died at San Francisco, January 14, 1937, age 55. Graduate of Denver and Gross Medical College, 1909, and licensed in California the same year. Doctor Green was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Moffitt, Thomas William. Died at Hollywood, January 4, 1937, age 67. Graduate of Starling Medical College, Columbus, Ohio, 1893. Licensed in California in 1923. Doctor Moffitt was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

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O'Connor, Thomas Charles, Jr. Died at Lodi, January 13, 1937, age 44. Graduate of the University of California Medical School, San Francisco, 1927, and licensed in California the same year. Doctor O'Connor was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Wagner, Henry Lewis. Died at San Francisco, December 27, 1936, age 77. Graduate of the Julius Maximilian Universität, Würzburg, Bavaria, 1884. Licensed in California in 1887. Doctor Wagner was a retired member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

Component Auxiliaries

Los Angeles County

A Christmas program featured the luncheon of the Woman's Auxiliary to the Los Angeles County Medical Association on December 22 at the County Medical building. Only about fifty members were present, but it was one of the most delightful meetings of the year. The choir boys from St. Thomas' Episcopal Church gave a beautiful selection of Christmas music, and the table decorations were particularly festive and attractive.

It was announced that \$26 had been made at the recent party given by Mrs. Joe Zeiler in her own home, which sum will be used for circulating health plays among the schools.

Dr. Harlan Shoemaker announced plans for President Roosevelt's birthday ball, being sponsored by the County Medical Society, and asked the coöperation of the Auxiliary.

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Fresno County

On December 1 the Fresno Auxiliary to the California Medical Association held a card party in place of the regular meeting. The purpose of this party was to obtain funds to purchase subscriptions to *Hygeia*.

We are happy to report we were successful in obtaining fifty-five subscriptions. Thirty-five of these are pri-

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Robert M. Furlong, chairman of the Publicity and Publications Committee, Linden Lane, San Rafael. Brief reports of county auxiliary meetings will be welcomed by Mrs. Furlong and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

vate and twenty are to be placed around in the community in such places as large beauty parlors, three high schools, the State College, County Library and its branches.

Fifty persons attended the party, which was a very enjoyable affair.

MRS. KENNETH J. STANIFORD.



San Diego County

The regular luncheon meeting of the Auxiliary to the San Diego County Medical Society was held December 8, 1936, at the University Club. The president, Mrs. F. G. Lindemulder, conducted the meeting.

It was announced that the Medical Society Bulletin has given one full page for our use. Mrs. R. Emerson Bond will be editor for this page.

Posters are to be given to every member of the Auxiliary for use in the doctors' offices. The posters will tell of the radio programs sponsored by the American Medical Association.

Mrs. E. H. Christopherson announced work of the public relations group. Mrs. Elmo Crabtree held a quiz on *Hygeia*, with a review of the value of the magazine.

Members of the Auxiliary presented a play, "A Doctor's Christmas," written by Mrs. Mark Glaser, State Chairman of Hygeia.

ELIZABETH R. BOLFORD.



San Francisco County

The monthly meeting of the round table on *Causes and Cure of War* was held on Wednesday, January 6, at the County Medical Society building, under the leadership of Mrs. Fred H. Zumwalt. Dr. E. Guy Talbot, western secretary of the National Council for Prevention of War, gave a very enlightening and stimulating talk on *Can We Keep Out of War?* He answered that question by first showing the ever-growing trend toward a European war, with the United States involved. Dictatorships, the scrapping of treaties, and the armament race, combined with the Spanish and Japanese situations, are bringing us nearer to a general conflagration.

Doctor Talbot stated that the causes of war are political, economic, and psychological, and that at the present time certain newspapers and magazines are building up an emotion of hatred, which was a great factor in the Spanish-American and World wars.

There are three important bills before Congress now that, if passed, would be a factor in the prevention of involving the United States in war. First, the bill to nationalize the munitions industry, that is, control by the Government. Second, to take the profits out of war, which is a bill presented by the Nye Investigation Committee. This committee found that for every three men killed in the World War, one millionaire was made. And third, a bill to strengthen the neutrality legislation. At present our neutrality bill expires in May, and it applies only to the embargo on implements of war. Doctor Talbot thought that it should also apply to raw materials, as oil, cotton, etc.

To close his talk, Doctor Talbot quoted a small line from Admiral Sims' article in *Freedom of the Seas*, which holds the kernel of the situation:

"... a decent regard of humanity should be placed ahead of gold."

MRS. EDWARD M. LIPSETT.



Santa Clara County

A luncheon was given by the Woman's Auxiliary to the Santa Clara County Medical Society on Monday, January 4, at the Hotel De Anza.

Dr. Dorothy Hazeltine Yates, assistant professor of psychology at San Jose State College, was guest speaker, her subject being *Psychology in Everyday Practice*.

Opposition to Forced Retirement Law for Physicians.—In a recent letter it was stated that a bill, termed the "Pomaret law," had been introduced in the French legislature according to which the members of all professions will be obliged to surrender their diplomas at the age of sixty-five and discontinue their work without any recompense in the form of a pension from the state. Violent opposition to such a proposal is appearing from all sides, and a medical journalist said that he would be eligible for retirement in three months and then either be ready for the soup line by 1939 or be obliged, like so many unemployed here in Paris, to earn a living by singing in the streets. Maurice Mordagne, the leader of the medical students' union, quotes such a letter received by him, in an article in the August 22 *Press médicale*, which reflects the reaction of the professors and medical journalists on the forced retirement bill. As to the faculties, Professor Villard of Montpellier is quoted as saying that the medical profession in France does not seem to have awakened to the potential dangers of such a bill if passed. Many physicians would be obliged either to die of hunger or seek asylum in a charitable institution. Another professor of the Paris Medical School who is familiar with conditions in smaller communities states that the applications of such a law would give temporary relief in an overcrowded profession only if some measures were adopted to reduce materially the numbers of licenses to practice granted annually. Professor Sergeant stated that every effort must be made to fight against the dangers of state medicine, which threatens to reestablish the serfdom suppressed by the French Revolution.

The proposed law would affect not only members of the technical (physicians, dentists, architects, engineers) but also those of non-technical professions (teachers in liberal arts); hence Professor Fedel of one of the high schools is quoted as saying that many discoveries have been made by men and women above the age of sixty-five. The campaign to retire such individuals without pension at that age is being led by ignorant opportunists and recently naturalized foreigners. Why not apply such a law to holders of public offices, many of whom have rendered the state invaluable service after the age of sixty-five? Many physicians even at seventy are still active and in possession of all their faculties, thus rendering indispensable aid by their advice, gained through many years of experience, to younger colleagues. Professor Faure, gynecologist, cited instance after instance of men of seventy or over who were a contradiction of the statement made by the supporters of the bill that a surgeon ought not to operate after the age of sixty-five.

The syndicat (union) of physicians in the department of the Seine has recently studied the records of one hundred foreign students and physicians during a period of four months and found that the majority of those who applied for naturalization and permission to practice were granted these demands by the government. It would appear more necessary to subject such applications to a stricter control than to try to force retirement of older men. The latter, if the bill passes the legislature, would not help young graduates born in France or its colonies as much as it would the recent influx of foreigners.—*J. A. M. A.*

Congress of Physical Therapy, X-Ray, and Radium.—The second cruise of the Latin-American Congress of Physical Therapy, X-Ray, and Radium will take place March 9 to 28, to Guatemala City, Guatemala. One boat will sail from Philadelphia March 9, and another from New Orleans March 10. The congress has been arranged for the week of the inauguration of the president of Guatemala, and visitors will participate in the festivities at that time. There will be three scientific sessions—Tuesday morning and afternoon, March 16, and Saturday morning, March 20—at the National University School of Medicine, the intervening time to be spent in a trip to the interior of Guatemala. Physicians who wish to attend should apply to Dr. Norman E. Titus, 730 Fifth Avenue, New York, president of the congress, or to Dr. Cassius Lopez de Victoria, 1013 Lexington Avenue, executive director.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 7-11. Olin West, M. D., 535 North Dearborn Street, Chicago, secretary.

California Medical Association, Del Monte, May 3-6. F. C. Warnshuis, M. D., 450 Sutter Street, San Francisco, secretary.

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Pacific Coast Surgical Association, Seattle, Washington, and Victoria, B. C., February 24-27. H. Glenn Bell, M. D., University of California Hospital, San Francisco, secretary.

Medical Broadcasts*

American Medical Association

The American Medical Association and the National Broadcasting Company are presenting the second series of dramatized health broadcasts, under the title "Your Health." The first broadcast in the new series, the thirty-second dramatized cooperative broadcast under the title "Your Health," was given October 13. The theme for 1936-1937 differs slightly from the topic in the first series, which was "Medical Emergencies and How They Are Met." The new series is built around the central idea that "one hundred thousand American physicians in great cities and tiny villages, who are members of the American Medical Association and of county and state medical societies, stand ready, day and night, to serve the American people in sickness and in health."

The program will be on the Blue network instead of the Red, as originally announced.

The topics are announced monthly in advance in *Hygeia*, the health magazine, and three weeks in advance in each issue of the *Journal of the American Medical Association*.

The time of the broadcast is Tuesday afternoon, two o'clock, Pacific time.

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San Francisco County Medical Society

A radio broadcast program for the San Francisco County Medical Society for the month of February is as follows:

Tuesday, February 2—KYA, 6 p. m.
Tuesday, February 9—KYA, 6 p. m.
Tuesday, February 16—KYA, 6 p. m.
Tuesday, February 23—KYA, 6 p. m.

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Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of February is as follows:

Tuesday, February 2—KECA, 10:30 a. m., The Road to Health.
Saturday, February 6—KFI, 9:15 a. m., The Road to Health.
Saturday, February 6—KFAC, 10:15 a. m., Your Doctor and You.
Tuesday, February 9—KECA, 10:30 a. m., The Road to Health.
Saturday, February 13—KFI, 9:15 a. m., The Road to Health.
Saturday, February 13—KFAC, 10:15 a. m., Your Doctor and You.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Tuesday, February 16—KECA, 10:30 a. m., The Road to Health.

Saturday, February 20—KFI, 9:15 a. m., The Road to Health.

Saturday, February 20—KFAC, 10:15 a. m., Your Doctor and You.

Tuesday, February 23—KECA, 10:30 a. m., The Road to Health.

Saturday, February 27—KFI, 9:15 a. m., The Road to Health.

Saturday, February 27—KFAC, 10:15 a. m., Your Doctor and You.

Wage Worker May Have Only One Federal Account Number.—Regardless of the number of employers a wage-worker may have, he can have only one account number or identification card for participation in the federal old-age benefits system under the Social Security Act, the Social Security Board emphasized today.

In issuing this statement, in response to inquiries from various sections of the country where workers having more than one employer have reported receipt of more than one identification card with differing account numbers, the Board advised each employee affected to take or send such cards to his local post office, where proper correction will be made.

The Board stated that this situation was due to the erroneous belief on the part of employees that they should file an application with respect to each job.

In emphasizing that an employee can have only one Social Security account number, the Board explained that the number of the account is permanent and is not affected by number of jobs engaged in or by changes in employment.

However, an employee who gives good reasons to the Social Security Board may have his account number changed.

The American Public Health Association's Sixty-Sixth Annual Meeting.—The American Public Health Association announces that its sixty-sixth annual meeting will be held in New York City, October 5-8, 1937.

A large eastern membership will receive that information with satisfaction. Not since 1921 has the Association met in the world's greatest city.

The sixty-fifth annual meeting took place in New Orleans in October. It attracted an attendance of 1,650 health authorities, representing forty-five states, Canada, Cuba, Mexico, and nine other foreign countries. The officers of the Association are reminding themselves of this registration in a state where the membership numbers less than one hundred and asking themselves what the registration will be in New York City, where the membership counts up to nearly five hundred within the city limits alone. An overnight's ride will enable more than one-half of the Association's five thousand members to attend the convention.

The National Organization for Public Health Nursing will meet with the American Public Health Association in 1937 for the first time. This large and important organization is expected to add another thousand to the registration lists.

The following related societies will meet with the Association as usual: The American Association of School Physicians; International Society of Medical Health Officers; Conference of State Sanitary Engineers; Conference of State Laboratory Directors; Association of Women in Public Health; and Delta Omega.

Dr. Reginald M. Atwater is the executive secretary of the Association, and the headquarters offices are at 50 West Fiftieth Street, New York, N. Y.

Social Security Allotments.—Federal grants totaling approximately \$2,326,000 for public assistance in three states were announced by the Social Security Board recently. California receives \$562,224.67 for aid to the needy blind and to dependent children; Connecticut, \$525,035.18 for aid to the needy aged; and Washington, \$1,238,731.06 for all three forms of assistance. California, as well as Washington, is among the twenty-four states cooperating in all of the public-assistance programs under the Social Security Act.

The amounts allotted to the states for each form of assistance and the number of individuals being aided under each plan, according to December estimates based on reports for the past nine months, are as follows:

State	Aid to	Federal Grant January 1 to March 31, 1937	Estimated Number of Individuals Aided in December
California	Blind	\$222,075.00	4,600
California	Children	340,149.67	22,650

With about 1,117,200 needy aged, 32,160 needy blind, and 290,240 dependent children receiving assistance from combined federal and state funds, it is estimated from reports for the past nine months that in December a total of approximately 1,439,600 persons were being aided under these three provisions of the Social Security Act. Forty-three states (including the District of Columbia and Hawaii) have plans approved under the Act for one or more of these programs—forty-two for old-age assistance, twenty-eight for aid to the needy blind, and twenty-seven for aid to dependent children.

University Enrollments in the United States: Fall Semester, 1936-1937.—The following figures have been compiled from the recent article in *School and Society* by President Raymond Walters of the University of Cincinnati. The original statistics did not separate the University of California at Los Angeles from the total figures for the University of California.

California (Berkeley alone, 13,681)	22,122
Columbia	14,662
Minnesota	13,864
Illinois	12,919
New York University	12,893
Ohio State	12,334
Michigan	10,646
Wisconsin	10,071
Washington (Seattle)	8,909
Texas	8,281
City College of New York	8,196
Harvard	8,111
University of California, Los Angeles	6,935
Louisiana State	6,823
Pennsylvania	6,608
Nebraska	6,544
Hunter College	6,506
St. John's	6,226
Chicago	6,170
Cornell	6,115
Boston University	6,025
Pittsburgh	5,866
Northwestern	5,833
Pennsylvania State College	5,575
Temple University	5,478
Syracuse	5,440
Indiana	5,344
Iowa	5,321
Purdue	5,298
Oklahoma	5,272
Yale	5,133
Brooklyn	5,000
Iowa State	4,843
Alabama	4,657
Kansas	4,465
Michigan State	4,393
University of Southern California	4,370
Loyola (Illinois)	4,306
Missouri	4,294
Oklahoma Agriculture and Mechanical College	4,187

Western Schools Not Included Above

Arizona	2,170
California Institute of Technology	805
College of the Pacific	885
Loyola (Los Angeles)	453
Montana	2,034
Occidental	678
Oregon	2,713
Oregon State	3,722
Pomona	813
Redlands	511
Santa Clara	445
St. Mary's	502
Stanford	4,023
Washington State	3,579
Whittier	467

Federal Grants to States for Assistance to Aged Persons.—Federal grants totaling \$2,724,615.10 for public assistance in California, Hawaii, Maryland, Michigan, Nebraska, Rhode Island, and Vermont were announced by the Social Security Board today.

The grants cover the period from January 1 to March 31, 1937. The amounts allotted to the states, the form of assistance for which each grant was made, and the number of individuals being aided under each plan in January, based on reports received for the past ten months, are shown in the following table:

State	Aid to	Grant	Estimated Number of Recipients
California	Aged	\$1,399,024.49	61,500

Health Officers' Training Course Scheduled at the University of California.—Continuing its drive to assist state health departments in training adequate public health personnel, the University of California has organized a second training course for sanitary inspectors, to be conducted on the University campus, under the direction of Dr. Karl F. Meyer, professor of bacteriology, from February 8 to May 4, 1937.

The first attempt in the United States to train sanitary inspectors on a large scale was made on the University campus during the summer of 1936, when forty-five men from nine western states and the Territory of Hawaii were put through a rigorous training course.

According to Doctor Meyer, the activities of the modern sanitary inspector are very broad. He must be able to meet men in all stations of life and be prepared to use diplomacy and ingenuity in enforcing public health laws. The training course is designed to develop a professional attitude and to teach the fundamentals of sanitation and the control of communicable diseases.

Eight weeks of the course will be given to lectures, conferences, laboratory practice, and group field trips. The final four weeks will consist of practical study in county and city health departments.

Certain entrance requirements will be enforced. Anyone interested in enrolling in the course may get further details from Karl F. Meyer, M.D., 3525 Life Sciences Building, University of California, Berkeley, California.

Prof. José Arcé of Buenos Aires Addresses San Francisco Chapter of Pan American Medical Association.—San Francisco had the honor of entertaining a distinguished visitor in the person of Prof. José Arcé of Buenos Aires, who arrived in this city on February 1 as the guest of the San Francisco Chapter of the Pan American Medical Association.

Rarely among confrères in any land has a physician attained the eminence in so many cultural fields and public welfare activities that is allotted this outstanding leader from South America's progressive republic. As president of the Argentine Chapter of the Pan American Medical Association, professor of surgery at the University of Buenos Aires, rector of the University, and senator of Argentina, Professor Arcé came to this country to promulgate medical Pan Americanism, to give scientific addresses and to conduct operative clinics before the chapters of New York, Washington, Los Angeles, San Francisco, etc. He also observed facilities for teaching graduate physicians in this country and addressed the students of the medical schools in the cities that he visited.

On Wednesday, February 3, at 8:15 p. m., Professor Arcé addressed the San Francisco Chapter of the Pan American Medical Association at the home of the San Francisco County Medical Society on "Preliminary Pneumothorax in Thoracic Surgery—The Importance of Its Use."

Thursday morning, February 4, at 9 a. m., he conducted an operative clinic under the auspices of the local chapter, performing a number of abdominal operations, including interventions on the gall-bladder, gastro-intestinal tract, and uterus. He also gave a scientific address before the faculty and students of the University of California Medical School on February 3 in Toland Hall, and addressed the faculty and students of the Stanford Medical School on February 5 in Lane Hall.

Professor Arcé was accompanied by his associates, Prof. Antonio Egeus and Prof. Adolfo Landivar.

Federal Old-Age Benefits.—With the Post Office Department now reporting receipt of 22,129,617 employee account number applications for participation in the federal old-age benefits program of the Social Security Act, a breakdown by states shows New York, with 3,433,631 applications, at the top of the list, the Social Security Board has reported.

This revised count of all applications on file in the 1,072 typing centers was made for the Board by the Post Office Department, and shows the totals for individual states. It supplements the Department's initial national total of 21,338,120 as of December 16, 1936, and represents an increase of 791,497 over the first report.

The Board stated that the present total of applications received should be considered as a progress report, for many thousands of Forms SS-5 are coming into post offices daily. The incompleteness of the present total is borne out by the fact that more than 24,000,000 workers are already represented on the employers' forms—known as "Employer's Application for Identification Number"—received at the Board's wage records office at Baltimore, Maryland.

Workers in seven of the leading industrial states account for more than half of the total applications, with New York first, and Pennsylvania second with 2,165,478. The next five are: Illinois, 1,680,059; Ohio, 1,469,837; California, 1,324,928; Massachusetts, 1,189,203; and Michigan, 1,109,435.

Totals by geographic divisions are: New England, 2,102,902; Middle Atlantic, 6,554,860; East North Central, 5,336,304; West North Central, 1,652,741; South Atlantic, 2,249,706; East South Central, 782,137; West South Central, 1,233,134; Mountain, 386,261; and Pacific, 1,730,117.

California Department of Industrial Relations: Report to Governor's Council—Safety Department.—The Industrial Accident Commission adopted the dusts, fumes, vapors, and gases safety orders, to be effective on December 28, 1936. These orders are the result of more than a year's study, many meetings of employers and employees with the Commission, and public hearings on the subject.

The orders require that all places of employment in which there is a hazard from dusts, fumes, vapors or gases shall be so arranged that these substances will either be prevented from being disbursed into the atmosphere breathed by the employees or, in those cases where this cannot be done, the employees will be furnished with approved respiratory equipment so that the air will be free from these substances. It is expected that by these means the dreaded disease silicosis will be eliminated from California.

The Mechanical Power Transmission safety orders and the revised logging and sawmill safety orders were also adopted, and became effective on January 1, 1937. Many meetings have been held between the employers, employees, and the Commission on this subject, and the orders as presented have the unanimous support of both employers and employees in the industries affected. These orders apply to every place of employment in which there is machinery and require that the belts, pulleys, sprockets, gears, shafting, etc., be guarded, so that there will be no hazard in their operation.

The revision of the mine safety orders is about complete. The orders are now in the hands of the printer, and the public hearings on these orders will be held in the near future.

The adopting of the new orders on dusts, fumes, vapors and gases, the adoption of the revised orders on logging and sawmills, and on mechanical power transmission and the proposed adoption of the mine safety orders will provide for places of employment the latest and best known means of preventing accidents in those industries and from the type of machinery covered by the orders.

Chairman T. A. Reardon and Commissioner Frank C. MacDonald of the Industrial Accident Commission appreciate the help that has been received from the employers and employees, and the independent consulting engineers who have given so freely of their time and knowledge in the preparation of these orders.

Federal Old-Age Retirement Benefits.—Under Treasury Department regulations, employers of one or more persons coming under federal old-age retirement benefits provisions of the Social Security Act are responsible for the filing of applications for an old-age benefit account number on behalf of their employees. The old-age benefits program went into effect January 1, 1937. . . .

Regulations No. 91 of the Bureau of Internal Revenue provide that employers after January 1, 1937, must make periodic reports to the Bureau in which the account number of each employee will be listed as the means of assuring proper credit to the employee's account for wages earned and taxes paid.

"Inasmuch as employers will eventually have to make sure that every employee has a Social Security account number in order to make required reports to the Treasury, it is evident," the Board's statement said, "that the more employees who file their applications now, the fewer will be the cases in which the employers will have to take action later."

Circumstances under which employers are required to fill out and file applications for employees are defined by Treasury Decision 4704 as follows:

"If an individual who is an employee on the last day of the period covered by any information return (see articles 402 to 405, inclusive, of Regulations 91) has failed to file an application for an account number on Form SS-5, the employer shall file an application for the employee on or before the tenth day after such last day. If an employee has failed to file an application on Form SS-5 prior to the date he attains age sixty-five, or the date he dies before attaining age sixty-five, or the date he leaves the service of the employer, the employer shall file an application for the individual on or before the tenth day after such date."

An employee, according to the Treasury Department's decision, must advise his employer as to the number of his account as soon as he receives it.

First International Conference on Fever Therapy.—The First International Conference on Fever Therapy will hold its sessions on March 29, 30, and 31, 1937, at the College of Physicians and Surgeons, Columbia University, New York City. The first day will be devoted to the discussion of physiology, pathology, and methods of production of fever. Dr. Frank W. Hartman, Henry Ford Hospital, Detroit, Michigan, is chairman of the committee arranging this section of the program, and Dr. Charles A. Doan of Ohio State University is secretary.

The second day is to be spent in the consideration of miscellaneous diseases treated by fever, such as chorea, rheumatic carditis, ocular diseases, arthritis, leprosy, meningococcus infections, undulant fever, tuberculosis, tumors, skin diseases, etc. This session will be arranged by Dr. Clarence A. Neymann, 104 South Michigan Boulevard, Chicago, Illinois, with the assistance of Dr. Frank H. Krusen, Mayo Clinic, Rochester, Minnesota, as secretary.

The morning of the third day is to be devoted to the consideration of syphilis. Dr. Walter M. Simpson, Miami Valley Hospital, Dayton, Ohio, is chairman of this section, which has as its secretary, Dr. Leland E. Hinsie, New York State Psychiatric Institute, New York City. In the afternoon of the same day, the treatment of gonorrhea by fever is to be discussed under the chairmanship of Dr. Stafford L. Warren, Strong Memorial Hospital, University of Rochester, Rochester, New York. The secretary of this committee is Dr. Charles M. Carpenter, Rochester, New York.

Ministries of Health from many countries have indicated their intention to send official representatives to the conference.

The official language of the conference is to be English.

Those desiring to participate are requested to communicate with the chairman of the Section in which they are interested. The manuscripts of all papers must be submitted to the appropriate chairman before February 1, 1937. Selection for the program will be made by February 15.

All who plan to attend the conference are urged to register promptly with the general secretary, Dr. William Bierman, 471 Park Avenue, New York City. The registration fee is \$15.

Federal Unemployment Assistance.—Grants totaling \$222,609.98 to cover state budgets for the administration of unemployment compensation laws in California, Kentucky, Minnesota, and Vermont were announced by the Social Security Board today.

The amount granted to California was for \$111,043.51, to cover the period from October 1 to December 31, 1936. The total amount that has been granted to California to date for this purpose is \$363,704.85.

Fifth International Congress of Hospitals.—At the congress in Rome, May, 1935, the International Hospital Association decided to hold the 1937 sessions in Paris. Previous sessions had been held in Atlantic City, Vienna, and Knocke Sur Mer, Belgium. The meetings will occur during the International Exposition, which will group the exhibits and products of more than fifty countries under the general caption, "Art and Technology."

Dr. Malcolm T. MacEachern of the American College of Surgeons is vice-president of the International Hospital Association. The Federation of the Hospital Unions of France has been designated officially by the Ministry of Public Health to cooperate with the International Hospital Association, and the program and arrangements for the congress are now being completed.

The meetings will be held at Paris from July 6 to 11, 1937, and will include visits to some of the large hospitals, the Cancer Institute, and the principal agencies engaged in public health work. At the time of the congress, scientific and pleasure tours will be conducted in various parts of France.

Persons attending the congress will be granted important reductions in rates when traveling on French and foreign railroads. The exposition authorities also will give special privileges to visitors.

The chairman of the Committee on Arrangements for the congress is M. Albert Chenevier, who is secretary-general of the Department of Public Assistance in Paris. Further information may be obtained from M. Chenevier, No. 3 Avenue Victoria, Paris IV, France.

Social Security Account Numbers.—Emphasizing that it is to the employer's and the employee's own interest to secure Social Security account numbers well in advance of the date they are actually needed for the periodic information returns required by the Bureau of Internal Revenue, the Social Security Board recently advised those employees and employers, who have not already done so, to file their applications immediately. At the same time, the Board stressed the fact that current non-possession of an account number is not a bar to the hiring of an employee. Application for account numbers should be made as soon after entering on duty as possible, however.

Bureau of Internal Revenue regulations, the Board stated, require employers to file periodic information returns giving their own identification numbers, and the name and account number of each of their employees who is required to have an account number. The regulations also require an employer to file an application for an account number for any employee who has failed to do so by the time the first information return is due. The time limit for filing of the first return, covering the period January 1 to June 30, 1937, is July 31.

In response to queries on how to obtain and file application forms at this time, the Board outlined the application procedure now being followed by employers and employees as well as by those who enter business or become employed in included employments in the future.

Employees' applications for account number—Form SS-5—will be available upon request at all local post offices, at the field offices of the Board, at offices of Collectors of Internal Revenue, and at the offices of the Board in Washington. They may be returned to local post offices through the employer, through a labor organization, or by mail or personal delivery.

Employers' applications—Form SS-4—may also be obtained at local post offices, field offices of the Board, from Collectors of Internal Revenue, and from the Social Security Board in Washington. Completed employers' applications are to be sent directly to the wage records office of the Social Security Board in Baltimore, Maryland.

The Centennial of the University of Louisville Medical School.—The University of Louisville Medical School is the second oldest medical school now in existence west of the Alleghenys and the oldest municipal medical college in the United States. It celebrates its centennial March 31 to April 3, 1937, at Louisville, Kentucky.

The Alumni are urged to make their plans now to attend their alma mater and participate in the celebrations. . . . The historic Old Kentucky Home at Bardstown and Lincoln Memorial at Hodgenville are also included in the itinerary. Mammoth Cave is within easy motoring distance for those who wish to visit this natural wonder. Lexington and the famous race-horse stables are but a short distance from Louisville and in the heart of the bluegrass region.

Postgraduate Course on Neuropsychiatry in General Practice.—The medical staff of the Menninger Clinic will conduct its third annual postgraduate course on Neuropsychiatry in General Practice, April 19 to 24, inclusive, at the Menninger Clinic, Topeka, Kansas. The course this year will include a brief introduction to the fields of neurology and psychiatry and a specific application of this knowledge to the large group of cases of psychoneuroses, psychoses and psychogenic and neurologic disorders which every physician meets in his daily practice. Suggestions made by those who took the course last year have been embodied in this year's program, in order to make it applicable to the most common practical problems of the physician.

As in previous years, several guest speakers, prominent in the fields of neurology and psychiatry, will appear at the evening sessions of the course.

Bureau of Vital Statistics: California State Board of Health.—*Births*—During July there were 7,416 births registered as against 7,056 during the corresponding month last year. This brings a total of 47,497 for the first seven months of 1936, as compared with 45,614 for the similar period of 1935.

Marriages.—There were 5,932 marriages in September of this year, bringing the total for the nine months to 44,938, while in September of 1935 there were 5,286 marriages with a nine months' total of 41,590, an excess of 3,348 marriages registered this year over last year (during the first nine months).

Deaths.—There were 6,042 deaths in May and 5,908 in June, as compared with 5,958 and 5,651 during the corresponding months last year. During the first six months of the year, there were 38,730 deaths, as compared with 36,787 in 1935 and 34,352 in 1934—an increase of 4,378, or 12.7 per cent, within the last two years, and of 1,943, or 5.3 per cent, over last year.

During the first six months there was an increase of 13.2 per cent among the epidemic diseases accounted for largely by an increase of 160.0 per cent in measles, 89.3 per cent in whooping cough, 52.8 per cent in influenza, and 62.5 per cent in dysentery, over the first six months' period last year. On the other hand, the degenerative diseases, cancer, diseases of the circulatory system, nephritis and senility, increased 3.3 per cent over the number recorded during the first six months last year. There were 2,143 infant deaths from January to June, 1936, an infant mortality rate of 53.5 per 1,000 live births, as compared with 1,952 deaths and a rate of 50.6 per 1,000 live births during the corresponding period last year.

Maternal deaths also show an increase in number, to be expected with the increased number of births. The increase is disproportionate, however, for while live births increased from 38,558 in 1935 to 40,081 in 1936, or 3.9 per cent, maternal deaths rose from 183 to 200, an increase of 9.3 per cent. The maternal death rate rose from 4.7 per 1,000 live births in the first half of 1935 to 5.0 during the first six months of 1936.

Suicides have increased from 763 to 798, an increase of 4.6 per cent, while external causes have increased 7.2 per cent from 2,812 during January to June, 1935, as against 3,015 in the same months of 1936. During the same period, pneumonia jumped from 2,100 to 2,469, an increase of 17.6.

LETTERS

Concerning Index Catalogue and Surgeon-General's Library.

LOS ANGELES COUNTY MEDICAL ASSOCIATION

Los Angeles, Calif., December 18, 1936.

To the Editor:—The medical profession considers that the Index Catalogue is one of the most valuable items for the advancement of the science of medicine, for the continued progress that the profession of medicine is making to protect the lives of our people, and to increase the health standards of this country. The Index Catalogue is of inestimable value.

The usefulness of the Index Catalogue is dependent upon the completeness of the files of medical publications contained in the library of the Surgeon-General's office—the greatest medical library in the world. To insure the value and usefulness of the Index Catalogue, the attached resolution adopted by the Los Angeles County Medical Association, with a membership of 2,400 doctors of medicine in Los Angeles County, was unanimously adopted at the annual meeting of the Association held December 17, 1936.

Respectfully yours,

E. VINCENT ASKEY, M. D.,
Secretary.

RESOLUTION

WHEREAS, The value and usefulness of the Index Catalogue is dependent upon the completeness of the files of medical publications contained in the library of the Surgeon-General's office—a public, national, medical library, the greatest in the world, serving in its present form of administration with satisfaction the medical profession and the medical libraries of our country; and

WHEREAS, In recent years the annual appropriation of the Congress has been wholly inadequate to provide sufficient funds to acquire the current medical books and periodicals issued throughout the world, so that they might be available for use throughout the country and for inclusion of the Index Catalogue; therefore be it

Resolved, That the Los Angeles County Medical Association, consisting of 2,400 members, urges Congress to appropriate annually to the library of the Surgeon-General's office an adequate sum for current medical books and periodicals and for the purchase of back publications lost during these recent years when the amount granted was grossly inadequate, thus depreciating the completeness and usefulness of the library's collection; and an additional sufficient sum annually, for as many years as may be required, in order to make for the greatest possible completeness of the collection and its Catalogue; and be it further

Resolved, That a sum be appropriated annually to defray the cost of printing regularly each year not less than one volume of the Index Catalogue; and be it further

Resolved, That a copy of these resolutions be spread upon the minutes of this Association and sent to the President of the United States, the presiding officer of both Houses of Congress, the Secretary of War, the Surgeon-General of the Army, and to CALIFORNIA AND WESTERN MEDICINE with the request for publication; and that these resolutions be published in the Bulletin of the Los Angeles County Medical Association with the request that the members send a copy to their local members of Congress requesting their support of these measures.

Concerning the fight against cancer.

To the Editor:—The American Society for the Control of Cancer has recently organized a Women's Field Army and in March will put on an extensive campaign of education throughout the United States and attempt to obtain enlistments. The campaign will be national in scope, and it is expected that the President will issue a proclamation. The Society has asked all local committees which it has built up during the last few years to cooperate with it at this time in broadcasting our slogan: "Fight Cancer with Knowledge." . . .

It seems quite fitting that at the close of the first decade of the New York City Cancer Committee's work, we can look forward to still greater educational achievements by our combined efforts in the decade to come.

Faternally yours,

(Mrs.) ELLA H. RIGNEY,
Publicity Adviser.

December 7, 1936.

FACTS ABOUT CANCER

The most recent group to mobilize its strength against a great and cruel scourge is the Women's Field Army of the American Society for the Control of Cancer. This nation-wide organization of the women of America will conduct a steady and relentless war to save, not to take human life. It is the kind of happy wholesome fight against fear and ignorance in which everyone can and should willingly take part.

The enemy is a cold and subtle killer which last year took more than 140,000 lives in the United States alone. It has been estimated that there are between three and five hundred thousand sufferers from this disease alive today. Perhaps half of them might be saved if knowledge of the signs and symptoms which might mean early cancer were given to them and if they were also strengthened by courage to act on that information without delay.

Concerning donation to Lane Library: Letter of thanks.

STANFORD UNIVERSITY
OFFICE OF THE PRESIDENT

January 4, 1937.

My dear Doctor Warnshuis:

May I through you thank the members of the California Medical Association on behalf of the University for the recent check for \$122.50 to be credited to the Lane Library Book Fund.

With much appreciation and every good wish for the coming year, I am

Faithfully yours,
RAY LYMAN WILBUR,
President.

Concerning proposed legislation on milk.

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

January 14, 1937.

To the Editor:—The enclosed copy of a letter which I have addressed to the members of the California State Legislature from San Francisco is forwarded to you that you may know of these circumstances, and particularly of my reaction to the proposed legislation referred to.

Sincerely,

J. C. GEIGER, M. D.,
Director of Public Health.

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

January 14, 1937.

The Members of the California Legislature from San Francisco, Addressed.

I wish to invite your attention to two bills now before the Legislature: Heisinger A. B. 50 and Thorp A. B. 77. The passage of these bills will be inimical to the public health of San Francisco particularly, in that they are destructive to our local milk ordinance and milk inspection service.

Under our milk ordinance, the entire supply comes from non-reacting tuberculin-tested herds and is of but two grades: "Grade A pasteurized" (99.5 per cent) and "Certified" (raw) (0.5 per cent). The proposed legislation will remove these safeguards to force into the San Francisco market raw milk of other grades, including the so-called "Guaranteed" and others lower, as well as pasteurized grades of milk from non-tested and presumably tuberculous herds.

The placing of all milk inspection in the State undoubtedly will result in inadequate remote control and lower

standards than exist in San Francisco today. These proposals are basically wrong, from the viewpoint of efficient public health administration, not only for San Francisco, but for California.

These proposed legislative instruments are a distinct menace to public health, for they will open up channels of infection for tuberculosis and other diseases, especially in infants and children. I point these situations out to you that there may be no letting down to safeguards built up over a period of years, particularly since they may mean the difference between health and happiness on the one hand, and disease and death on the other. The passage of these bills would be a public health tragedy.

Sincerely,

J. C. GEIGER, M. D.,
Director of Public Health.

Concerning reorganization of Franklin Hospital medical staff.

To the Editor:—The medical profession in and about San Francisco no doubt will be interested in the following news item:

On November 4, 1936, at a general meeting of the German General Benevolent Society, the constitution and by-laws of the Society were amended to discontinue taking members with medical service. A second amendment was also unanimously passed at this meeting establishing the policy of taking in associate or group associates who shall receive, on periodic payment of dues, hospitalization. The benefit to be received by the associate or group associates is limited strictly to hospitalization. Laboratory and x-ray work are excluded because these services are held to be the practice of medicine. The associate or group associates shall have free choice in the selection of their physician.

The Society is legally bound to continue to take care of their present members, particularly those members possessing life certificates. The Board of Directors is strongly urging the present members to change their status to that of associate members.

This action removes the German General Benevolent Society as a potent future competitor of the medical profession. This organization has been active since 1852, and the Board of Directors and voting members are to be commended for the about-face at a time when so many agencies are encroaching upon the private practice of medicine. They cooperated completely with the suggested medical policy.

Likewise, if and when, the San Francisco County Medical Society and/or the local hospitals establish a constructive collective hospitalization program, Franklin Hospital will be ready to cooperate 100 per cent.

Yours very truly,

LEROY BROOKS,
Chief of Staff, Franklin Hospital.

Explanatory Note to Above Letter.—The German General Benevolent Society in San Francisco has given to its members, for seventy-five years, medical, surgical, and hospital care on the periodic payment of dues. The Society owns and operates the Franklin Hospital in San Francisco. The patient's choice of physician has been limited to the appointed or closed staff of the Franklin Hospital. The staff has given its professional care to members with practically no compensation.

On November 24, 1936, at a general meeting of the German General Benevolent Society, the by-laws were amended to discontinue taking members with medical care. At the same meeting, a second amendment to the by-laws was passed offering associate members hospitalization without medical care, with free choice of physician on a periodic payment plan. By this action the Franklin Hospital is no longer in direct competition with the medical profession.

The Board of Directors and voting members are to be commended for their cooperation at a time when so many agencies are making inroads into the private practice of medicine. They have set an example which could well be followed by other organizations.

MEDICAL JURISPRUDENCE†

TAX PROVISIONS OF THE FEDERAL SOCIAL SECURITY ACT AND THE CALIFORNIA UNEMPLOYMENT INSURANCE LAW

By HARTLEY F. PEART, ESQ.
San Francisco

The Federal Social Security Act was passed by Congress and approved by President Roosevelt August 14, 1935. This act is in reality a series of acts, and for the purposes of this discussion we shall deal specifically with but two portions of the Act:

I. OLD-AGE BENEFITS

In order to provide for old-age benefit payments or pensions for employees who have reached the age of sixty-five years, the Act provides for:

1. A wage tax on employees, commencing on January 1, 1937. For the first few years of the Act the tax is levied at the rate of one per cent of the wages earned, and progresses upon a graduated scale until the tax becomes three per cent of the wages in 1949, and continues at that rate thereafter unless the Act is subsequently amended. This tax is to be collected by the employer by deducting the amount of the tax from the wages of his employee as and when paid. The employer is made liable for the amount of the tax. The amount of this tax may not be deducted by the employee in computing his net income for regular income tax purposes.

2. An excise tax is levied upon the employer's payroll and at the same rates as above, with the following exception: Any wages paid to an employee in excess of \$3,000 a year are not considered by the employer in determining and deducting the employee's tax or in determining the tax which the employer is to pay. The sum collected by the employer, together with the tax payable directly by such employer, is to be collected by the Bureau of Internal Revenue and paid into the Treasury of the United States, where an "Old Age Account" is to be set up.

Certain types of labor are exempted from the provisions of the Act. Agricultural labor, domestics, casual labor, employees of the United States, any state, counties, municipalities and subdivisions or instrumentalities thereof, officers or members of the crew of a vessel documented under the laws of the United States or any foreign country, individuals over the age of sixty-five, and employees of any organization operated for religious, charitable, scientific, literary, etc., purposes, no part of the earnings of which inure to the benefit of any private person, are all exempted from the provisions of this act.

All employers and all employees, with the exception of those included in the exempted fields noted above, are included within this act, regardless of the number of individuals employed, and it is to be remembered that the money so paid into the Federal Government is to be used to create old-age benefits for those employees who are included within the provisions of this act and whose employers were liable for the tax provided by this act to the Federal Government. The amount of the monthly benefit which becomes payable upon the employee attaining the age of sixty-five years and retiring, depends, of course, upon the amount of money which has been paid into the United States Treasury by reason of the wages earned by him. The minimum and maximum monthly payments are \$15 and \$85 per month, respectively.

II. FEDERAL UNEMPLOYMENT INSURANCE

The second taxing measure of the Social Security Act with which we are here concerned is sometimes termed the "Tax on employers of eight or more." It is also commonly termed the "Federal Unemployment Insurance Tax." In order to provide a form of unemployment insurance, the Social Security Act further provides for a tax on employers of eight or more. This tax is separate

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, containing copy submitted by Hartley F. Peart, Esq., has been established by the California Medical Association Council. Each issue will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

from and in addition to the tax previously discussed which was for old-age benefits. This tax is paid by employers and is not deducted from the employee's wages. The tax was at the rate of one per cent on the employer's total payroll between January 1, 1936, and December 31, 1936. It will be two per cent in 1937 and three per cent in 1938 and thereafter. This tax applies only to employers who on each of twenty days during the calendar year, each day being in a different week, employed eight or more persons. The money so collected is to be paid into the Treasury of the United States, where a fund known as "The Unemployment Trust Fund" has been created. Under the provisions of this statute, the following employers are exempted: Agricultural labor, domestics, service performed as an officer or member of the crew of a vessel on the navigable waters of the United States, service performed by an individual in the employ of his son, daughter, or spouse, and service performed by a child under the age of twenty-one in the employ of his father or mother, service performed in the employ of the United States Government, a state, county, municipality or political subdivision thereof, or of an instrumentality thereof, service performed in the employ of an organization operated exclusively for religious, charitable, etc., purposes, where no part of the net earnings inure to the benefit of any private individual. This federal act provides that if the state wherein the employer's place of business is situated adopts a suitable unemployment insurance plan, the employer may credit against his payment to the Bureau of Internal Revenue that amount of state tax which will not exceed 90 per cent of the federal tax. The purpose of this provision was designed to encourage the enactment of state laws patterned after the federal act. California has adopted such a law, which is known as the "California Unemployment Insurance Law." This is the third taxation statute under discussion here and will be considered in more detail below. Just how the funds collected by the Federal Government under this second taxing measure of the Social Security Act will be used for the benefit of unemployed individuals is not specifically set forth.

The federal act provides that those states which adopt their own plan, and which has been approved, will be granted federal money with which to finance the administration of the state plan.

CALIFORNIA UNEMPLOYMENT INSURANCE

The third related tax measure is entitled the "California Unemployment Insurance Law." This act was placed upon the statute books of this state on June 25, 1935, to conform to the general plan for unemployment insurance which was to be suggested to the several states by the federal act. Section 2 of the California act provides:

This act is enacted as a part of a national plan of unemployment reserves and social security and for the purpose of assisting in the stabilization of unemployment conditions. The imposition of the tax herein imposed upon California industry alone, without a corresponding tax be imposed upon all industry in the United States, would by the corresponding penalty upon California industry defeat the very purposes of this act set forth in Section 1.

It is further provided that the Act shall take effect only upon the adoption of legislation by the Federal Government providing for an unemployment insurance tax. The California act and the federal act are very similar. The same employers are taxed, to wit: those employing eight or more individuals on each of twenty days during the calendar year, each day being in a different week. Its benefits extend to the same employees, to wit: those employed by the employers last mentioned. Practically the same occupations are excluded. There is an important difference, however. The California plan is financed by both employers and employees. The employers' tax rate was fixed at .9 per cent for 1936, 1.8 per cent for 1937, and 2.7 per cent for 1938 and thereafter. These figures were chosen so as to enable the employer to take advantage of the credit allowance provided by the federal act. Consequently, a California employer being taxed under both the state and federal acts will not have to pay more than the percentage of his total payroll which is required by the federal act to satisfy both taxes. In addition, each employee is taxed .5 per cent of his salary

for 1936, 1 per cent of his salary for 1937, and at the same rate for his salary for 1938 and thereafter. The law provides that employees shall not pay more than one-half of the amount paid by the employers. As a result, the employee's tax for 1936 was reduced to .45 per cent from .5 per cent. As in the case of federal tax for old-age benefits, the employee's share of the tax is to be withheld from the employee's wages by the employer and paid by him. This money is to be paid into an "unemployment administration fund."

There has been considerable discussion as to the constitutionality of each of the three taxing measures which have been briefly discussed above. As yet, there has been no decision by the Supreme Court of the United States as to the constitutionality of the Social Security Act and the two taxing measures therein provided, namely, the old-age benefit provision and the unemployment insurance provision. However, the Supreme Court of the United States has passed upon the constitutionality of the New York Unemployment Insurance Law, which is similar to the Unemployment Insurance Act of California. The United States Supreme Court, with eight of the nine judges sitting, failed to reach a decision, as the judges were equally divided in their opinions as to the constitutionality of the New York law. Consequently, the decision of the New York Court of Appeals, which court held the Act constitutional, had to be affirmed. No written opinion was rendered by the United States Supreme Court.

The Supreme Court of the State of California recently had occasion to pass upon the validity of the California act. In the case of *Gillum vs. Johnson, Treasurer of the State of California, et al.*, 92 Cal. Dec. 647, the court concluded that the Act was constitutional and ordered the defendants, the State Treasurer, the State Controller, and the Unemployment Reserves Commission of the State to comply with the provisions of the Act.

Cases involving the constitutionality of the Social Security Act have been filed in several of the lower federal courts, and within the near future we may expect a decision from the Supreme Court of the United States in regard to the constitutionality of this federal act.

SPECIAL ARTICLES

HOBBY EXHIBIT: LOS ANGELES COUNTY MEDICAL ASSOCIATION

"Interests far from the operating theater and the diagnosis chart are indicated in the current hobby show of Los Angeles County Medical Association members.

"Held in the Association's lounge, 1925 Wilshire Boulevard, the show will be open daily from 9 a. m. to 9 p. m. during the week of January 11. In charge are Dr. E. Vincent Askey, secretary, and S. K. Cochems, executive secretary."

The above are the opening paragraphs of an article which appeared in the Los Angeles *Times*.

Members of the California Medical Association will be able to appreciate how generous was the response to the request to members that they place on exhibition their "hobby collections" and own handiwork for the pleasure of fellows, by perusing the list of exhibits which follows and noting their character, as evidenced in the illustrations. The first annual hobby show of the Los Angeles County Medical Association was voted a great success. List of exhibits follows:

Howard Andrews, M.D.

Acclaimed as one of the finest collections of firearms in United States history; a display of some two hundred weapons for holster, belt and pocket, including the so-called pepper-box weapons, flintlock pistols, heavy dragoon models, the early pocket revolvers, and an exceptionally fine display of Deringer pistols, including a duplicate of the one used in the assassination of Abraham Lincoln.

Stephen G. Seech, M.D.

A display of rare Austrian stamps—just a small portion of Doctor Seech's collection.

Paul K. Selve, M.D.

Landscapes in oil. Illustrating that art is not the least of our members' attainments.



Fig. 1.—"Hobby Show": Los Angeles County Medical Association. Photograph of southeast corner of Lounge Room in Headquarters Building.

Katherine M. Close, M.D.

A seascape in tempera—a lovely bit of color and composition.

Philip S. Doane, M.D.

A carved bench and various items of beautifully carved work.

Randall Hutchinson, M.D.

Bead work. Exceptional design and workmanship.

Arthur Bowen, M.D.

Hand-tooled leather, including an exceptionally beautiful desk set, book covers, card cases and boxes.

Joseph Savage, M.D.

Heads in charcoal that show the work of a true artist. Doctor Savage also had on display an exquisitely made ship model, illustrating his other hobby.

Paul Z. Hebert, M.D.

An unusual technique of pictorial art in glass.

Saul Robinson, M.D.

A series of oils that lend art value and dignity to the display.

Sven Lokrantz, M.D.

Two exhibits, entitled "Fantasia" and "Land of Make Believe," in relief art. Two items in the display that created a great deal of attention and which illustrate many hours of painstaking work—truly exquisite offerings.

H. O. Bames, M.D.

A display, through stamps and literature, illustrating that Vienna is but three days away from Los Angeles.

F. H. Brandt, M.D.

The pencil is not a forgotten implement with which to create art. This is exemplified in the display of penciled landscapes by Doctor Brandt.

Salvatore R. Monaco, M.D.

Pottery of unusual design and beauty. A hobby that must be of great interest.



Fig. 2.—"Hobby Show": Los Angeles County Medical Association. Photograph of northwest corner of Lounge Room in Headquarters Building.



Fig. 3.—"Hobby Show": Los Angeles County Medical Association. Photograph of southwest corner of Lounge Room in Headquarters Building.

Lloyd Mills, M.D.

Two concertos for piano and orchestra and a rhapsody for two pianos.

Lowell S. Goin, M.D.

Excerpts from "Mass, in E flat." A composition by Doctor Goin.

George Laton, M.D.

Two compositions, entitled "Cavaliers" and "Prayer" (Masefield—Poems), Volume I.

A. Marians, M.D.

Unusual specimens of colored photography.

Harold Lincoln Thompson, M.D.

The camera, as an instrument for art, has long been recognized. Doctor Thompson illustrates what may be done with this mechanism in the creation of true art. His landscapes, his portrait of a dog, and a study of Lincoln in the Lincoln Memorial at Washington, can only be appreciated by being seen.

Charles L. Lowman, M.D.

Unusual stamps from Doctor Lowman's extensive collection.

Harold Dewey Barnard, M.D.

Those who know Doctor Barnard might expect a large mounted rainbow trout, a big bear skin, an exceptionally fine deer head, and other items that delight the heart of the hunter, and these were all displayed.

Norval William Haddow, M.D.

Doctor Haddow's hobby is "climatology." Graphs to illustrate his interest in this hobby were displayed.

Harold F. Whalman, M.D.

Motion pictures in colors were shown at stated intervals during the exhibit by Doctor Whalman, who proved that colored motion pictures are not things for only commercial enterprise.

E. R. Lambertson, M.D.

California landscapes in oil, with the color and sunshine and atmosphere that is California.

Cora Smith King, M.D.

A small portion of an extensive collection of pressed plant life of the West.

Robert H. Kennicott, M.D.

The oils of Doctor Kennicott brought to the "Hobby Show" some of the modern spirit in art in still life and figures.

Marcia A. Patrick, M.D.

An oil in brilliant colors and a California seascape, both adding dignity and interest to the display.

Clinton D. Hubbard, M.D.

We are sorry indeed that space forbids Doctor Hubbard displaying his complete collection of sea shells from the seven seas. It is hoped that next year the entire collection may be shown. To say the least, it is most interesting and unusual.

Hans von Briesen, M.D.

Whittling is what Doctor Briesen entitled his exhibit; an exhibit of four lithographs of old paintings, the frames and the lithographs processed to give an antique effect. These attracted a great deal of attention. Also several carved wooden figures, including a box of chessmen.

Jonas C. Kopelowitz, M.D.

Wood working is Doctor Kopelowitz' hobby. On display he has various items, including a specially constructed card-table top and a toy aeroplane.

George Dock, M.D.

A series of photographic enlargements of some of the greater bits of scenery in this country. One of exceptional interest is the picture of a terrace and garden at Sir William Osler's house, 13 Norham Gardens, Oxford, England.

James Reeve Dean, M.D.

Precision rifle shooting holds Doctor Dean's interest. On display were various telescopes and precision rifles, together with the ammunition used.

Cyril B. Courville, M.D.

Firearms of the Civil War. Collectors of firearms show much interest in this complete collection. Weapons used by both the North and South are on display.

Frank E. McCann, M.D.

Pictorial photography. Four landscapes and an exceptionally fine study of an Indian head.

Raymond L. Schultz, M.D.

Intricate surgical instruments made by himself.

Orrie Edw. Ghrist, M.D.

Doctor Ghrist enjoys travel to far places. Several years ago he made a trip to the South Sea Islands. A very fine collection of stereopticon pictures, which he took himself, were on display for the enjoyment of visitors to the exhibit, with a stereopticon.

Henry G. Bieler, M.D.

Doctor Bieler is an artist in modeling and sculpturing. His pieces, modeled in wood, are of exceptional interest.

Louis K. Guggenheim, M.D.

Landscapes in oil. More of Doctor Guggenheim's work would have been welcome. One study in particular shows a very fine appreciation of the value of color.

Robert A. Campbell, M.D.

Wood working is shown to be truly an art in the display of Doctor Campbell. Various types of beautiful woods have been carved into beautiful things from the turning lathe of this member.

Edward L. Sudlow, M.D.

Doctor Sudlow's display—just a few old books—but what books! Every older visitor to the exhibit stopped at that display. A collection of McGuffey's Readers. Some of you may remember the first reader. It starts off with a picture of a dog: "The Dog, The Dog ran."

Frank B. Young, M.D.

An exhibit of comparative pathologic and physiologic osseous conditions. This display is of exceptional interest to the scientifically minded.

John W. Nevius, M.D.

An unusual and beautiful book, containing tuberculosis stamps collected from all parts of the world.

THE PRACTICE OF MEDICAL SPECIALTIES IN HOSPITALS*

A Report to the Medical Problems Group of the San Francisco Medical Society

The problem of the proper ethical and legal relationship between hospitals and certain medical specialties has been a vexatious one. It was left largely to individual action until recently, when the question of organized medicine approving the various relations was forced by the many schemes for hospital insurance. It has been argued that the specialists involved should not use the lever of the recognition of hospital insurance schemes as a means of solving their problems. That would certainly be true were it not for the fact that organized medicine is being asked for the first time to officially approve of certain practices which are probably both illegal and unethical. The fundamental problem has no connection with insurance, but concerns the legal and ethical aspects of the practice of certain medical specialties in hospitals.

CORPORATIONS AND MEDICAL PRACTICE

Let us first consider the legal aspects of the problem. There have been definite legal decisions regarding the right of corporations to practice medicine. The most recent one is that involving the Pacific Employers' Insurance Company. In that decision the court held that the company could not circumvent the law by employing licensed physicians to practice for it. A similar decision was that in the case of *People vs. United Medical Service,*

Inc., N. E. 157, which the Supreme Court of Illinois handed down on February 14, 1936. The court, in unmistakable language, proscribed corporations from practicing medicine even though they attempt to do so through the medium of salaried employees who are licensed physicians. The Supreme Court of the State of California has said: "That a corporation may not practice law, medicine, or dentistry, is a settled question in California." (*Parker vs. Board of Dental Examiners*, 216 Cal. 285, 14 P. (2d) 67.)

RADIOLOGY

That the practice of radiology is the practice of medicine is also a settled question. The House of Delegates of the California Medical Association in May, 1936, adopted a resolution reading in part:

Resolved, That radiology and pathology, being in all of their several parts and subdivisions the practice of medicine, etc.

The House of Delegates of the American Medical Association in May, 1936, adopted a committee report containing the following:

It reiterates the principle enunciated by the House of Delegates at Cleveland in 1934, "That the practice of radiology, whether for diagnostic or therapeutic purposes, constitutes in fact the practice of medicine." The action of the House of Delegates in 1925, establishing a section on radiology, confirms this principle.

Since radiology is the practice of medicine, it is illegal for hospitals to engage in the practice of it. However, some hospital administrators maintain that they are not practicing medicine when they manage only the business side and arrange with a licensed physician to provide the professional services. Let us look carefully into this contention. The practice of medicine is a contract between a patient who needs medical services and a doctor who can render it. Because that service is a personal as well as a professional one, the laws of various states have decreed that no person or corporation may come between the doctor and his patient. If the patient pays his money to the hospital, the contract is between the patient and the hospital, the latter agreeing to furnish the radiologist's service. The hospital is entering as a third party. The physician owes his allegiance to the hospital which employs him, and he can owe but a secondary and divided loyalty to the patient.

Very definite legal opinion is available on this subject. The Supreme Court of the State of California, in the case of *Painless Parker vs. Board of Dental Examiners*, made the following comments in answer to the contention that there is a distinction between the practice of dentistry and the purely business side of the practice:

The law does not assume to divide the practice of dentistry into that kind of departments. Either one may extend into the domain of the other in respects that would make such a division impractical if not impossible. The subject is treated as a whole. If the contention of appellant be sound, then the proprietor of the business may be guilty of gross misconduct in its management and violate all standards which a licensed dentist would be required to respect and stand immune from any regulatory supervision whatsoever. His employee, the licensed dentist, would also be immune from discipline upon the ground that he was but a mere employee and was not responsible for his employer's misconduct, whether the employer be a corporation or a natural person. On grounds of public policy such a condition could not be countenanced.

No one would dispute the right of any person to own a dental office equipment. The question most appropriate here is whether the thing owned is used for a given purpose by a person lawfully entitled to so use it. Ownership is not the absolute test of the right of use.

The court went on to say that if Parker's contention is sound, the Dental Practice Act is impotent to accomplish the purpose it was intended to serve, namely, to promote the safety, health, and welfare of the people of the State.

The legal side of the issue can be righted only by one method. The physician who provides the medical service must make the contract with the patient, and must collect the fee in such a way that the patient knows he is paying that physician.

REIMBURSEMENT TO THE HOSPITAL

Such being the case, how is the hospital to be reimbursed for the use of its space, equipment, materials,

* This report was made by a committee consisting of Robert Stone, M.D., Randolph G. Flood, M.D., Emery M. Seeburt, M.D., Leon O. Parker, M.D., president of the Medical Problems Group, and Frank Hand, M.D., secretary of Medical Problems Group, and submitted for publication by the committee.

etc., or whatever part of them it furnishes? At the present time there are three types of arrangement by which hospitals are reimbursed: First, salary—the hospital taking the money and paying the physician a stated percentage of the gross or net income of the department. Second, commission—the hospital taking the money and paying the physician a stated percentage of the gross or net income of the department. Third, reimbursement—the physician collecting the fees and paying the hospital an amount which is in relation to the space, etc., provided, *not* in relation to the income of the physician. Assuming that the fees are collected by the physician, the legal aspects are satisfied, but what about the ethical aspects if the money is turned over to the hospital to be divided on any of the above bases?

AMERICAN MEDICAL ASSOCIATION CODE OF ETHICS

Chapter 3, Article 6, Section 4, of the Code of Ethics of the American Medical Association states:

It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group, or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary, or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.

In elaborating on this the Bureau of Medical Economics of the American Medical Association states:

Where physicians become employees and permit their services to be peddled as commodities, the medical services usually deteriorate, and the public, which purchases such services, is injured.

From this we deduce that any arrangement which permits the hospital to profit from the "medical fees" is unethical. Whatever arrangement is made must be based on the space, equipment, etc., provided, not on the medical fees collected. The salary arrangement is thus definitely unethical. It makes whatever profit the hospital receives directly proportional to the fees collected.

COMMISSION OR PERCENTAGE BASIS

The commission or percentage basis is equally unethical on the above grounds. The hospital stands to profit directly in proportion to the fees collected. It is equally unethical on the ground of fee-splitting. When a hospital is on a percentage basis, it is directly interested in the amount of practice done. It is not limited by the rules of medical ethics and can go out and advertise its equipment, or even the professional attainments of the physician it employs. This has been done by some institutions, and so far as the physician is concerned, constitutes a voluntary or involuntary solicitation of patients. Such a percentage basis constitutes in essence an agreement by the physician to pay the hospital a definite amount for each patient it secures for him.

The remaining method is that of reimbursement on the basis of the full cost to the hospital of providing the department. In such an arrangement the physician agrees to pay the hospital a stated sum for the use of the space, etc., which it provides. This amount should be based on the value of the space occupied, just as it would be for space in an office building, plus items to cover whatever other expenses the hospital has in connection with the operation of the department. A proper amount can thus be fixed whether the physician is provided with space alone and provides everything else himself, or is provided with space, equipment and supplies by the hospital. If the hospital provides everything, it could base the amount charged on the number of patients examined. In other words, the radiologist would pay the hospital a stated amount for each examination performed. The amount paid by the radiologist bears no relation to the fee he collects. Can you imagine a hospital collecting an operating-room charge based on the amount of the fee collected by the surgeon?

WHO SHALL PRACTICE RADIOLOGY IN THE HOSPITAL?

Let us look briefly at the problem of who is to practice this specialty in the hospital. The license of a physician and surgeon gives to the person so licensed the right to

practice any branch of the healing art. The State does not recognize specialists. Hence, under the State law any physician who so desires can make x-ray examinations, give x-ray treatments, make tissue examinations, etc., being limited only by his own conscience. Organized medicine, however, steps in to try to elevate the standards of medical care above that required by State law. The American College of Surgeons and the American Medical Association have specified that, if a hospital desires to be recognized as approved for interne training, it must have the radiologic and pathologic services performed by a duly recognized specialist. Hence, so far as approved hospitals are concerned, only qualified specialists can render these services. In *small* hospitals, or those that do not wish to be recognized and classified, any physician who is willing to assume full responsibility for all the acts performed and for the diagnosis or partial diagnosis rendered, can do so. It is to be borne in mind here that the courts have held that "delegated acts, done by a lay person helping a doctor, must be pure mechanical functions not requiring the exercise of judgment. The physician is responsible for all that is done, and must exercise all the judgments. A doctor cannot delegate the 'right to practice medicine,' but can accept lay assistance which is given directly in accordance with the instructions of the doctor." In those hospitals not desiring to be recognized, any specialty can be practiced by any physician who is willing to accept full responsibility for all acts done.

EMPLOYMENT OF LAY ASSISTANTS

In view of the fact that every physician is responsible for the delegated acts of his lay assistants, it is essential that the radiologist shall have the right of selecting his lay help. This involves the determination of the conditions of their employment. Of course, it is assumed that all appointments are subject to the approval of the superintendent. In the case of *Painless Parker*, cited above, the Supreme Court of the State of California ruled that it is impossible to separate the business and professional parts of the practice of dentistry. How much harder it is to separate the technical and professional parts of the practice of medicine! They are intimately bound up. To be legally correct, the technicians must be directly responsible to the physician for all acts they perform. The physician, not the hospital, is legally responsible for their acts.

OTHER FACTORS

One further point in connection with the reimbursement scheme presents itself. Many hospitals claim that they are entitled to an excessive amount on the grounds that they are giving a monopoly, a ready-made practice, and a certain amount of good will. Let us discuss these features item by item.

It is true that most hospitals have only one roentgenologist and that he gets all the practice in that hospital. This condition has arisen because of the necessity for the supervision of the acts of technicians by a licensed practitioner. If the x-ray examinations were to be done as surgery is done, only when the roentgenologist were present, and if roentgenologists were to run about from one hospital to another as do surgeons, then they would have to charge more for their services, because each act would take much more of their time. Moreover, each and every doctor on the staff of a given hospital wants the roentgenologist to be present at the hospital at the same time as he is there, so that he can talk to him relative to his patient. He wants a full consultation, not just a written report. Hence, it has seemed expedient for these specialists to limit their practices to one hospital and be present as much of their time as the work there warrants. Thus, not only does the hospital give a monopoly *but it also asks the monopoly* of the particular specialist's time, either full time or on demand. Under the proposed plan there is no necessity for a monopoly if the staff does not desire to monopolize one specialist's time. They could appoint as many specialists in any one specialty as they desired, and each of these could pay the hospital an amount proportional to the use they made of the department or to the number and kind of examinations done or treatments given.

The idea of furnishing a ready-made practice applies only to hospitals who have as roentgenologist a young man just out of training, or a failure type who has not

been able to build a practice of his own. Most hospital staffs should, and do want, as consultant roentgenologists men who have established reputations and whose abilities are known. Such men can have a practice outside as well as inside a hospital. Instead of getting from the hospital a ready-made practice, they are giving to the institution the added prestige and good will of having them on the staff. They are a drawing card for the hospital, inasmuch as other practitioners are going to take their patients to that hospital where they can get satisfactory consultations. Moreover, few hospitals have enough work originating in the hospitals to keep a well-qualified man occupied for his full time, or to keep their equipment and space in use enough to repay them for the investment they have made. Hence, non-hospitalized patients must be attracted to the departments. This is accomplished only by having a physician in charge who commands the respect of his fellow practitioners. It is he, not the hospital, that attracts this kind of practice.

With regard to the question of good will, the same arguments apply as above. The hospital may provide a little good will to a young man just starting; but once he is established he provides good will to the hospital. Would any physician who "buys" a practice consider it necessary to continue to pay a good-will premium to the doctor from whom he bought it, after he, the purchaser, has once established himself?

HOSPITALS MUST PROVIDE GOOD RADIOLOGIC SERVICES

On the other hand, it might equally well be argued that it is absolutely necessary for a hospital to provide the means of good radiologic services, if that hospital is to be patronized by physicians who might bring their patients to it. It is to be remembered that the paying patients in a hospital are not the patients of that hospital *but of the physicians* who bring them there. If necessary, the hospital might have to pay a premium to a good, well-qualified, well-established specialist for devoting his time to work in that hospital, thereby helping to keep the beds filled.

PLACEMENT OF RADIOLOGISTS ON HOSPITAL STAFFS

One more point remains to be considered, namely, the method of selecting and appointing to the staff the particular specialists concerned. Very few physicians are consciously aware of the fact that most roentgenologists are now virtually employees of the hospital. While the hospital management may ask for a committee of the staff to help them select the specialist concerned, the actual appointment is not made by, or even on advice from, the governing medical board, but by the superintendent. All too frequently, as is to be expected under such an arrangement, the appointment is made, not on the basis of professional attainments, but on the amount of money the hospital is to receive. Analyzed on the basis of the facts revealed in this report, this means that the hospital management appoints the physician who is willing to give them the biggest percentage of the fees he collects. This arrangement places the specialist concerned in a very unprofessional position. That man who adheres most strongly to his ethical professional rights stands the least chance of being employed.

A REMEDY

This situation can be remedied by the professional staff insisting that all physicians be appointed to the staff in the same way. If the hospital management provides the space, etc., required on the basis of their financial investment in it, then that amount would be the same whomsoever was appointed. They would be interested then in having the medical board appoint that specialist whom the board considered most qualified. The specialist selected would be on the same professional status in the hospital as any other physician. He would not be an "employee allowing the hospital to peddle his professional services as a commodity."

Likewise the termination of the appointment of each specialist should be in the hands of the medical board.

RECOMMENDATIONS

In conclusion we recommend the following as the legal, ethical, and professional arrangement for the practice of certain specialties in a hospital.

1. The specialist or specialists concerned should be selected as are the other members of the professional staff,

namely, by the executive medical committee, on the basis of their qualifications, abilities, and professional standing.

2. They should then be appointed to the staff in the same manner as any other member of the staff.

3. The selected physician or physicians should then make arrangements with the hospital management to reimburse them on the basis of the value of whatever space, equipment, etc., the hospital is to provide. The radiologist, being legally responsible for the acts of his lay assistants, shall control the conditions of their employment.

4. The specialist so selected should make all contracts with the patients and make arrangements for the collection of his own fees.

5. The appointment should be terminated only for cause, as determined and recommended by the governing medical board by whatever name called.

6. If agreeable to the staff, and practicable, there can be no objection to the appointment of several specialists in the specialty, each to pay the hospital a pro-rated amount based on the number of examinations made or treatments given.

7. In those institutions where charity work is done, the radiologists must give their services free as do the other members of the staff. The hospital must bear the cost of such work (other than professional costs) as they do in the other departments.

EXAMPLE

8. Example 1. A hospital needs a radiologist on its staff. The medical executive committee of the hospital selects and recommends for appointment Dr. A. The Board of Trustees or similar body makes the appointment. Dr. A and the hospital management then determine and agree upon the monthly or per examination cost to the hospital of handling patients in the x-ray department. This cost will be based on whatever of the following items are provided by the hospital:

1. Space and janitorial service.
2. Heat, light, power, water, and telephone.
3. Laundry and linen supplies.
4. Interest on capital investment in equipment and furnishings.
5. Obsolescence on equipment and furnishings (which fund repays initial investment and covers replacements).
6. Supplies—tubes, screens, films, chemicals, stationery, etc.
7. Repairs.
8. Salaries of such lay help as the hospital provides.

Arrangement 1. Dr. A pays the hospital each month the amount determined as above.

Arrangement 2. The amount determined as above may be divided by the average number of treatments and examinations, and the cost per examination and per treatment determined. Dr. A pays the hospital that amount for each examination or treatment whether he collects from the patient or not.

Dr. B refers his patient to Dr. A (the radiologist) for an ex-ray examination or treatment. Dr. A performs the examination or treatment and renders a bill to the patient on his personal billhead. The patient may or may not pay. Regardless of that fact, Dr. A reimburses the hospital on the basis of either the first or second arrangement, above.

COMMENT

Is it possible to attain such an objective? The report of the Judicial Council of the American Medical Association to the 1936 House of Delegates of that body, which report was approved and adopted, contained the following:

It would seem that in this time of extensive changes in hospital economics the point had arrived at which further marriages between hospitals and staff physicians that make the doctor of medicine the servant of the hospital should be stopped and a series of attempts at divorce among the marriages that have already taken place should be instituted. Our accepted ethical principles are adequate at the present time. . . .

The same House of Delegates adopted the following paragraph in the report of the Reference Committee on Reports of Officers:

Your committee considers that the invasion by hospitals of the field of the practice of medicine should be condemned as a violation of the fundamental rights of physicians, and that it demands militant opposition, to the end that such activities cease.

From the hospital side we have the following statements from the president of the Catholic Hospital Association of America, Rev. Alphonse Schwitalla, as published in the May issue of *Hospital Progress*:

The annual meeting of the American Medical Association cannot but have, each year, the deepest possible significance for our hospitals. As the medical profession thinks, so hospital policies must be shaped or modified. . . . The physician felt in many localities the careless domination of lay groups, who could not possibly bring a professional attitude to bear upon medical problems. . . .

The maintenance of proper relationships between the hospitals and staffs is a fundamental issue. We cannot, therefore, but be convinced that when the House of Delegates of the American Medical Association "took a stand against hospitals which may wink at unethical practices or engage in them, "it was serving not only the medical profession, but also the finest ideals of hospital practice. We join in the sense of triumph which pervades the medical groups of the country. They have won a battle in which the issues were so basic that a redefinition of medical practice would have been imminent if the guide of warfare had turned in a different direction.

IN CONCLUSION

The legal and ethical principles established above are equally applicable to the other medical specialties when practiced in hospitals.

490 Post Street, San Francisco.

Respectfully submitted,

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DEATHS AMONG FOREIGN RACES IN CALIFORNIA DECLINE*

A study of mortality in California, by races, for the period 1926 to 1935, reveals the fact that deaths of members of the white race have increased more than 2½ per cent during the ten-year period. Deaths among negroes during this time have increased slightly. Indian deaths have remained stationary, and noticeable decreases have occurred in the percentages of deaths among Chinese, Japanese, Mexicans, and members of other races.

MORTALITY AMONG WHITES

In 1926 there were 50,578 deaths in California of members of the white race, and in 1935 there were 64,325 such deaths recorded in California. The percentage of the total increased from 86.1 in 1926 to 88.73 per cent in 1935. The numbers of deaths and the percentages for each year follow:

Year	Total White Deaths	Per Cent of Total
1926	50,578	86.10
1927	52,951	86.20
1928	56,431	85.18
1929	55,939	85.59
1930	56,457	85.31
1931	58,592	86.79
1932	59,205	87.55
1933	59,803	87.96
1934	60,051	88.19
1935	64,325	88.73

NEGRO DEATHS

In 1926 there were 1,130 negro deaths, 1.92 per cent of the total registered in California. In 1935 there were 1,499 such deaths, 2.07 per cent of the total.

Year	Total Negro Deaths	Per Cent
1926	1,130	1.92
1927	1,098	1.79
1928	1,233	1.86
1929	1,211	1.85
1930	1,174	1.77
1931	1,245	1.84
1932	1,310	1.94
1933	1,367	2.01
1934	1,390	2.04
1935	1,499	2.07

* From the *Bulletin*, California Department of Public Health.

INDIAN DEATHS

While there were 283 Indian deaths registered in 1926 and 344 such events registered in 1935, the percentage of the total is practically the same for each year.

Year	Total Indian Deaths	Per Cent
1926	283	.48
1927	267	.44
1928	346	.52
1929	368	.56
1930	418	.63
1931	308	.46
1932	334	.49
1933	314	.46
1934	320	.47
1935	344	.47

CHINESE DEATHS

Chinese deaths dropped from 710 in 1926 to 539 in 1935. The percentage of the total fell from 1.21 in 1926 to 0.74 in 1935.

Year	Total Chinese Deaths	Per Cent
1926	710	1.21
1927	715	1.16
1928	725	1.09
1929	707	1.08
1930	641	.97
1931	611	.91
1932	633	.94
1933	590	.87
1934	525	.77
1935	539	.74

JAPANESE DEATHS

The number of Japanese deaths in California dropped from 814 deaths in 1926 to 683 in 1935. The percentage fell from 1.39 in 1926 to 0.94 in 1935.

Year	Total Japanese Deaths	Per Cent
1926	814	1.39
1927	787	1.28
1928	808	1.22
1929	769	1.18
1930	771	1.17
1931	732	1.08
1932	696	1.03
1933	693	1.02
1934	662	.97
1935	683	.94

MEXICAN DEATHS

There were 5,121 Mexican deaths registered in 1926, 8.72 per cent of the total. In 1928 there were 6,362 such deaths, or 9.61 per cent of the total registered in California. Deaths among Mexicans fell in 1935 to 4,659, or 6.43 per cent of the total.

Year	Total Mexican Deaths	Per Cent
1926	5,121	8.72
1927	5,524	8.99
1928	6,362	9.61
1929	5,943	9.09
1930	6,306	9.53
1931	5,570	8.25
1932	5,014	7.41
1933	4,779	7.03
1934	4,725	6.94
1935	4,659	6.43

DEATHS AMONG OTHER RACES

Year	Total Deaths	Per Cent
1926	106	.18
1927	88	.14
1928	344	.52
1929	426	.65
1930	411	.62
1931	455	.67
1932	430	.64
1933	446	.65
1934	418	.62
1935	451	.62

This study of mortality indicates reduced populations among the Chinese, Japanese, and Mexican races in California. The enforcement of immigration laws affects the Oriental population within the State, and the reduced Mexican population, since 1930, is indicated with marked effect in the reduced numbers of deaths. It is presumed that the increased proportion of deaths among members of the white race is due, in part at least, to the heavy migration of white laborers from other states where particularly unfavorable economic conditions have prevailed.

MEDICINE'S INTEREST IN THE NEXT CALIFORNIA LEGISLATURE*

By PHILIP KING BROWN, M.D.
San Francisco

The frontier must always be the place of trail blazing, and all the United States is interested in the working out legally of a plan for better distribution of medical care in California.

We of the medical profession agree that we know a better plan is needed, but we should like to work it out ourselves. Our leaders have said: "(1) Medicine is, in effect, society's trustee in matters of disease and injury. (2) Medicine accepts this responsibility with the realization that, in the last analysis, the food of society must be the sole aim of its public policies. (3) Medicine's first practical responsibility is to see that, as far as lies within its power, its services are available to all men."¹ "The medical profession is fully conscious of the needs of the sick and the poor, and that great white-collar class who need our help so badly, and will, through our Association, have a way to care for them worked out."² But in the end we have agreed upon no plan and have accomplished precisely nothing. In the meantime a lot of glorified collection agency plans have been put forth, not one of which in this state, or elsewhere, have offered any real solution to the problem of hospital support or adequate medical care on a basis of reasonable profit to its doctor, and anything like complete service to the small wage-earner.³

In the meantime two great national agencies of citizens have taken up the problem and demand action, and some three thousand industries in the country have taken the initiative in developing some sort of medical care for their employees.⁴

TWENTIETH CENTURY FUND

The first of the national agencies to interest itself in the subject is the Twentieth Century Fund and its three thousand credit unions, representing some two million people. Perhaps no single movement has done so much to keep the resources of the masses fluid and usable as this credit union plan of E. A. Filene, organized under common employers, buying their own stock and lending to each other at times of emergency or unusual strain. Such credit unions as the school teachers' in New York City have capital of several millions, and lend at a low rate. While 6,900 banks have failed during the depression, no credit union has failed. Another brilliant idea of Mr. Filene has been a study of what members borrowed for, and it developed that 22 per cent was to cover the expense of unexpected illness. So Mr. Filene has done two more memorable things: to have exempted legally from attachments a certain amount of a man's holdings in his credit union, and secure federal support for the plan. In every state in the Union there are federal agents, as well as the employers of the unions, engaged in promoting the movement.

Mr. Filene and his Twentieth Century Fund have been giving a great deal of study as to how these two million members can buy medical care on a safer, surer and more reasonable basis.

FARM BUREAU ORGANIZATIONS

The next great national movement has originated in the Farm Bureau organizations, chiefly here in California. A study of what San Joaquin County has done through its county hospital has convinced farmers' wives that the opening of county hospitals to citizens generally was the answer. Thirty of California's fifty-eight counties have hospitals that accept paying patients under different conditions.

It is the purpose of this brief article to point out the dangers, difficulties, and wholly inadequate service which would accrue to the public if either of these plans were carried out.

*An address delivered at the National Farm Bureau convention December 8, 1936, in Pasadena.

¹ William A. Pusey, M.D., recently president of the American Medical Association, at the annual conference of secretaries of state medical associations in Chicago on November 18, 1936.

² William Moloney, M.D., retiring president of the Los Angeles County Medical Association.

³ The reader is recommended to study the Alameda plan in this State and the Wayne County plan in Detroit.

⁴ Details in the forthcoming volume by Elizabeth Marshall of New York.

EXPERIENCE OF THE CREDIT UNIONS

First, the credit union forces, having found out that nearly one-quarter of the money borrowed from the unions by their members was for medical care, sought to devise plans for procuring it on more practical terms than were offered by private practice or charity. Mr. Evans Clark, secretary of the Twentieth Century Fund, has published a volume on Budgeting for Health, and in it he has expounded very ably all of the methods that have been devised for lessening the costs of medical care to the small wage-earner. His criticisms of these plans are good. More than that, Mr. Filene himself gave the first \$5,000, which started seriously the Committee on the Costs of Medical Care. Both the profession and the laymen might easily feel that in such apparently understanding hands their several causes were safe, but somehow these able leaders were not good enough historians.

The age-old cause of lodge practice has seemed to appeal to the older credit unions in the East. They wish to accomplish what the medical profession regards as two utterly disastrous ends: the right of each union to hire doctors on salary, and the right of corporations to practice medicine. For sixty years, all over the United States, both of these principles have been fought vigorously by the organized profession, and the courts everywhere have sustained the rule that corporations may not practice medicine. Lodge practice has been an effort to buy medical care cheaply. All lodges have used their cheap medical service as an advertising influence, and the best of them pay \$100 to \$125 a month and hire one doctor for each one thousand members. Members are treated free; small fees are asked of dependents. Certain services are charged extra. The cost averages \$2 a month. Some of the lodges send 85 per cent of this East for certain causes which they support. Others spend goodly sums on orphan asylums, old people's homes, care of their tuberculous, and hopelessly ill. Emphasis is put chiefly on the benefit which appeals most in some particular neighborhood. There is no uniformity in policy. A few good doctors have undoubtedly done lodge work for a starter, some have undertaken it for political reasons, and a few try seriously to carry out their obligations. Some country towns without doctors have devised no better way of getting one to settle in their midst than to establish and develop some sort of a lodge, and then look about for the cheapest doctor they can find. It should be obvious that with the growth of the science of medicine and the need for some specialization, this sort of practice promises little. Most lodge doctors have endured but briefly if they have had any ambition or ability. It is only fair to say that the western credit unions which have sought to act individually have made a good many studies of how medical service might be procured at a price more reasonable than possible at present, and have been brought to see that most states will require some additional legislation before anything can be done, and then they look forward to asking the organized profession to give them its best plan. It is quite possible that our next legislature will pass some enabling act putting all health insurance efforts under the Insurance Commissioner and some board like the State Board of Health, in order that all such plans may be sound financially and medically before they go into operation.

STUDIES OF THE FARM BUREAU ORGANIZATIONS OF CALIFORNIA: COUNTY HOSPITALS

The second mass action was proposed by the Home Economics Department of the Farm Bureau Organizations throughout California, who have circulated petitions to all of their members and as many others as they can interest, hoping to get action from local boards of supervisors, who will make demands upon the counties to the end that the county hospitals may be opened to anyone. The latter part of the ordinance which they are supporting reads as follows:

"And pursuant to Part IV, Title II, Section 4003, of the Political Code, 1 to 5 inclusive, and Section 4223 of the Political Code, the Board of Supervisors of the county of _____ do hereby ordain, under the mandate of the people, that the county of _____ shall operate the county hospital and out-patient medical services for the welfare of the people of the county; that the part of the tax dollar which maintains the hospital and the out-

patient medical service shall be the yearly insurance of the people that the hospital and medical service will be available when and if they need it at the daily cost of the service, and the hospital shall not be operated on a tax levy for care of indigents. For those unable to pay in full for the service, they shall pay any part of the cost which they are able to pay.

"Those incapacitated by age, disease, or accident, not able to pay any part of the cost, shall be cared for free, on the same standard of service as those who pay.

"The Board of Supervisors of the county of _____ do further ordain that there shall be no stigma of pauperism attached to the hospital service provided by the county, and that such service shall be regarded, supported, and utilized in the same democratic spirit which prevails with relation to any other public service operated, supported, and maintained by public funds."

The whole issue of the county hospital is one that needs revision, and there are a few states, and one municipality particularly, that have solved the problem satisfactorily. Michigan extends the open door of its county hospitals to the doctors of the state, and the large county hospital of Buffalo, New York, does the same. Patients are encouraged to have their doctors attend them, and every effort is made by the public authorities to keep as many as possible of the people who are handled in the county hospitals under the medical care of their own physicians. What they pay these physicians is a matter entirely between doctor and patient. If they can pay a small sum for hospital care, they are charged it.

The trouble in California is that the county hospital in many counties is either the only one or is the best one. Los Angeles has spent between fifteen and twenty million dollars on its county hospital, and it is not surprising that the small wage-earner looks with some bitterness on the fact that out of whatever taxes he pays, part goes to support a hospital to which he has no access.⁵ The social service rule of the Los Angeles General Hospital states that if the family earnings are more than \$60 a month no member of a family of four may enter the hospital. If the earnings are \$60 a month or under, they are welcome. It is the feeling of the writer that every intelligent physician in the community will agree that out of the \$61 a month for even one person there is nothing to be saved to provide medical care for any illness. The Social Welfare Department of the State, which has some supervisory relation to this hospital, has no real control over it. Its authority is limited "to investigate and examine and make reports to the legislature on the conduct of institutions operated for the care of indigents." It is held by some counties that they are privileged to operate hospitals in which charges are made for certain patients, and they point to Section 4223 of the Political Code to justify their position. The claim is made, for example, by the San Joaquin General Hospital that Los Angeles, San Francisco, and Kern County operate under the pauper provision of Section 1. Section 4041.16 of the Political Code. The crux of the situation, however, lies in what was pointed out in a letter to Mrs. Turner of the Department of Social Welfare of Sacramento in which the legal department of the Attorney-General's office, in defining the term "county hospital," as used in the Kern County Hospital case, states that the legislature has never defined a county hospital, but that the decision of the court in the case of *Goodall vs. Brite* directed in its decree to the county and those officials in charge at the hospital "who should be admitted to its county hospital." The decision makes extremely plain that "no people of the class of persons described in paragraph 3 of the rules may be admitted to said hospital except in cases of emergency." Paragraph 3 authorizes the admission of persons unable to pay for and obtain proper and necessary medical, surgical or hospital care for themselves elsewhere than in the county hospital, deeming such persons obviously dependents, and leaving it to an admission board as to what proportion of the cost of hospitalization they are able to pay. As there are some thirty hospitals among our county hospitals who receive patients who pay something, this decision if maintained puts them all in the position of acting irregularly. It would be necessary for an act of the State

Legislature to be passed to open county hospitals to the public generally. This decision is quite the reverse of an opinion of the Attorney-General written to the District Attorney of Sonoma County November 7, 1934, in which it was argued that certain patients who could pay something should do so. The Attorney-General quoted the rule about our state insane asylums which requires payment from those who can afford it. There is another aspect of the county hospital question which needs to be pointed out. The Social Welfare Committee has divided these hospitals into five groups, of which only the first, containing sixteen hospitals, is accepted as class "A" by the American College of Surgeons. The one thing about all of them, which is absolutely wrong, is that they have volunteer staffs. The writer believes that this is not wholly true, because the San Joaquin Hospital is mentioned among those sixteen, and all of its doctors are paid something, although most of them get merely \$100 a month for what they do. The other four groups vary from a fair medical and surgical service, lacking one or more essentials, to boarding houses operated by a man and his wife in old wooden shacks where the county physician is telephoned to, to come and see anyone who seems to be sick enough to require some attention.

It would require \$50,000,000 to buy land and equip decent county hospitals for those counties that lack them in this state, and then the charge per day would have to be in the neighborhood of \$6 even in wards. The supervisors should take cognizance of the criticisms of the \$3 rate by the Fourth Appellate Court, Civil No. 1761, January 30, 1936: "The method used in reaching the daily cost per patient was so inaccurate and unbusinesslike that the result would not reflect the true daily cost to the county." Property taxes, depreciation, insurance, and interest charges on the investment in land and building, all should be made part of the cost.

There seems to be one answer to this entire situation. The great indigent and small wage-earning class of the community will have to be supported in sickness by taxation, insurance, or a combination of both. Given a compulsory health insurance law, and absolutely class "A" county hospitals like those, for example, in Los Angeles, San Joaquin, and San Mateo, all of the small wage-earners who entered such hospitals would have their bills paid from the insurance fund; the county would have to (as now) pay for the care of its dependents. The one other big change which the organized medical profession should fight for is that first-class county hospitals should be opened to every licensed doctor, so that he might follow his patient requiring hospitalization until his discharge. It works wherever it has been tried, and it would seem to be in the interest of both the medical profession and the public.

909 Hyde Street.

THE CONFERENCE ON SYPHILIS*

More than five hundred persons responded to the call of Surgeon-General Thomas Parran of the United States Public Health Service for a three-day conference in Washington recently on the control of venereal diseases, especially syphilis. Representatives of the American Medical Association, officers of state medical societies, and practicing physicians attended, as well as health officers and social service workers. The conference was asked to consider the question of venereal disease control from six principal points of view. The reports that were adopted by the conference as a whole on the third day were in substance as follows:

1. Estimates were presented of the prevalence of syphilis in the United States. A minimum of 681,000 new cases of syphilis was declared to be the probable annual incidence of the disease. Prevalence in the population as a whole was estimated variously at from 5 to 10 per cent of the population, including syphilis in all its stages from initial infection to the late sequelae. . . .

2. The section on the public health control of syphilis stressed the necessity for carrying treatment facilities to all persons of all economic strata. Emphasis was placed, however, on the fact that no desire existed on the part of

⁵ See "The Care of Dependents," a publication by the Los Angeles Budget and Research Department, p. 90, 1936.

* Excerpts from editorials published in *The Journal of the American Medical Association* for January 9, 1937.

the public health officials to undertake the treatment of all cases of syphilis at public expense. It was declared that whenever and wherever possible patients should be treated by family physicians in the usual manner and that the personal relationship of patient to physician should be maintained wherever possible. The section reported that in its judgment the treatment of indigent and borderline patients in clinics would be a necessity. Adequate social service for the clinic to ascertain the degree of ability to pay was dealt with in another section. Reporting of the venereal diseases was stressed as a necessity in their control. The section recommended that the Surgeon-General request reporting by name and address as in the case of other communicable diseases. This recommendation of the section was opposed from the floor of the conference and ultimately was amended to read, in effect, that reporting by name and address be encouraged where practicable, but that in other localities reports by number or by initials and date of birth be accepted for the present in order to allow opportunity for overcoming the well-known reluctance of physicians to report venereal diseases by name. The necessity for furnishing laboratory service gratis and for the free distribution of drugs needed in the treatment of venereal diseases through public health authorities was stressed. A recommendation to the effect that prophylaxis be regarded as an integral part of the syphilis program was opposed from the floor. The opposition, however, was overwhelmingly defeated and the report of the section, therefore, included the recommendation that prophylaxis be included in the antisiphilic program.

3. The section on treatment presented a voluminous report, of which the salient points were the importance of early treatment and the treatment of the pregnant syphilitic woman. Emphasis was laid on the necessity for continuous treatment except in the case of late syphilis in persons of middle age or beyond; on the importance of confining the distribution of drugs through public health departments to established preparations, namely, the arsenicals, bismuth compounds, mercury ointments, and possibly iodid preparations.

4. The section on medical follow-up of the venereal disease patient reported the importance and necessity for follow-up in certain types of cases. Much follow-up work can be prevented by efficient, courteous, and expeditious handling of patients on their first visit to the clinic. . . .

5. The section on coöperation of the private physician in the control of venereal diseases made a report which indicated the dual responsibility of the physician in any case of communicable disease, including the venereal diseases. This responsibility is for the patient and for the community. . . .

The principles here presented seemed in general to meet with the approval of all groups represented. Recognition was given to the fact that conditions in the United States differ widely in different localities and even sometimes within a single community, and that programs, subject only to general fundamentals, must be varied and adapted to meet local needs. . . .

In all probability most indigent patients in denser population centers will need to be treated in clinics. In smaller communities and rural areas, treatment of the indigent was recommended through the offices of family physicians. The recommendations included payment of the physician on such a basis as might locally be agreed on for services rendered to indigent patients. Certain questions were raised relating to the lack of uniformity of instruction in syphilology in the medical schools. . . .

CALIFORNIA STATE BAR CHASES AMBULANCE CHASERS*

The State Bar of California has a committee, known as Special Local Administrative Committee No. 1, whose duty is to investigate and institute prosecutions of ambulance chasers, both lay and attorney. The personnel of this committee is John E. Biby (chairman), John M. Bowen, and Robert M. Clarke; staff, Philbrick McCoy, counsel, and Herbert Hallner, special investigator.

The above-named committee has been successful in securing convictions and pleas of guilty in more than fifty cases. Many of the offenders have received jail sentences

of 180 days and fines in the amount of \$500. Among those convicted was a member of the medical profession.

Of interest to the medical profession is the fact that this committee has in several instances secured information to the effect that certain physicians are very active in the solicitation of business for certain attorney ambulance chasers. This condition appears quite aggravated among some of the physicians who conduct private emergency hospitals. One such offered medical treatment and hospitalization to an injured person if he would employ a certain attorney to prosecute his claim for damages, the cost thereof to be paid only out of any money recovered!

This State Bar committee frequently finds it difficult to prove the facts necessary to secure a conviction in these cases. Its investigations disclose that the attorney involved has received a written or telephone request from the injured person to call on him; and, when questioned, the attorney invariably says he did not know the request was instigated by the physician. The physician often excuses his conduct by stating that the injured person requested him to recommend an attorney.

The State Bar deserves commendation for the work it is doing to eliminate the evils arising out of ambulance chasing. Any member of the medical profession acquiring knowledge that a physician is in any manner aiding an ambulance chaser should report at once to any member of the State Bar committee or its staff, or to The State Bar, 440 Rowan Building, Los Angeles (Los Angeles telephone, Michigan 9551). Such coöperation with the State Bar will do much to purge both professions of the odium cast upon them by members who are aiding or coöperating as ambulance chasers.

HEALTH INSURANCE PROPAGANDA*

On Monday, November 23, 1936, a newspaper of the city, the *New York Herald-Tribune*, gave its columns over to a piece of propaganda which deserves attention. Under date of November 22, 1936, and presumably coming from Washington, a feature article is written, headed "Health Insurance Study Is Instituted by Security Board."

Like all propaganda, the "news-spread" necessarily must be tacked to some event, and so this time we find it tacked to some casual recommendations made by Harry Hopkins, WPA Administrator, in a speech to the United States Conference of Mayors recently; and, incidentally, it is also tacked to a report of the Executive Council of the American Federation of Labor. Then, not giving either the speech made by Mr. Hopkins or the substance of the report of the Executive Counsel of the American Federation of Labor, the propagandist in question hides his identity under the statement, "A spokesman for the Social Security Board." For the rest of a column and a half of ordinary newspaper space there is nothing but argument and propaganda, and little or no factual news. In the end the reader is left to wonder *who* is advocating health insurance, who is putting forth the arguments for it, who says that it is to be considered purely as a tax measure, and who is it that is forcing attention to it and arousing argument.

The stress presented in the newspaper broadcast consists primarily in the fact that existing systems of unemployment compensation and old-age benefits "are generally believed in Security Board circles as measures to bring health insurance to the fore" and "almost all European countries have comprehensive plans of health insurance providing cash benefits in disability and invalidity and supplying medical aid." The plea ends with the statement that it can be conducted on a pay-as-you-go plan.

In the September 1 issue of the *New York State Journal of Medicine*, editorial note was made of the "lull before the storm." An ominous silence was noticed on the part of the protagonists for health insurance. We were then aware that the protagonists of health insurance had not quit. We rather resent the fact, however, that *government agencies* should engage in propaganda to create a demand for something which the public has neither asked for nor needs.

The news release also announces that more time to study the proposition is asked. We seriously recommend that it be studied; that comparison be made of the morbid-

* By J. E. B.

* Editorial from *The New York Medical Week*, November 28, 1936.

ity and mortality statistics abroad with those here; that the uses which are made of preventive medicine abroad with that here be taken into account. We could go on at length, but of what avail to argue with those whose minds are made up. What can one expect from Walton Hale Hamilton, the economist head of the research division, a former member of the National Industrial Recovery Board! We know him through a different activity. He was one of those who, under Ray Lyman Wilbur, brought out the report of the Committee on the Costs of Medical Care which recommended health insurance; and he wrote his own special report on this thesis, which in itself was but an elucidation of the preconceived object of the committee, from the pen of its director, Henry H. Moore.

President Roosevelt has announced that there will be no measures proposed calling for the necessity of adding to our present heavy tax burden. Furthermore, the President, in his address in Jersey City, gave the profession assurances that it would be consulted and its wishes given attention when changes affecting medical practice came under consideration. Our conception of consultation and consideration does not envisage government spokesmen speaking for their preconceived ideas, long fixed, of how medical practice shall be arranged.

It has been jocularly said that the many governmental functionaries who speak publicly for the administration have so managed things that the Washington Administration can take more sides on any given question than is possible of geometrical demonstration. In this question of medical care, at least, let us have plain, straight thinking and speaking. There should be but one side to the problem. How to provide the highest possible *quality* of medical care to those of the public that need it, and to make provision that financial barriers shall not stop those needing it from getting it.

GUARDING THE SIGHT OF SCHOOL CHILDREN

The years of school life are usually the period of greatest stress and danger for eyesight, declared Dr. Edward Jackson of Denver, Colorado, at the annual conference of the National Society for the Prevention of Blindness, in Columbus, Ohio, recently. Doctor Jackson is Emeritus Professor of Ophthalmology at the University of Colorado. Speaking on "Guarding the Sight of School Children," he said:

"The prevention of blindness implies the conservation of partial sight, and is only complete when it is applied early in life. For the majority of people, the years of school life constitute the period of greatest stress and danger to their eyes.

"Accidents are responsible for 16 per cent of the causes of complete blindness, and more than half of these accidents occur to boys and girls under twenty.

"Prevention of disease has of late years been very widely applied, and results have far surpassed those of medicine and surgery in treating disease. Smallpox caused one-eighth of the blindness in the civilized world before vaccination was introduced, and still causes many cases of blindness where it is not practiced. But this proportion of blindness has been completely prevented by vaccination.

"Oliver Wendell Holmes, professor of anatomy, said that it was necessary to go back three generations to prevent some forms of disease. Many have approved of the statement, but we have not yet begun to apply prevention to one whole generation. Care of the eyes during school life is an attempt to make such an application to the prevention of blindness.

"In the school, we have light that is very inferior to the light of outdoor living. The sun at different times of the day gives light of 1,000 to 10,000 foot candles. In schoolrooms we rarely find light about 100 foot candles on the desk of the students, and sometimes it runs down to ten or five—or even two or one—and the children's eyes are expected to stand their school work under such bad conditions.

"Anyone can judge the effect of poor light by taking a telephone directory, which always has small print in it, and looking at it first in an ordinary indoor light, and then holding it where the sun will shine upon it. No one can miss the lesson of greater ease in using powerful light.

"When people think the light is too bright, it is usually because they have been trying to look at it. Our sources of light are not generally to be used like Neon signs, but to illuminate the desks or studies which we are trying to carry on. In the schoolrooms, many errors are tolerated with reference to the lighting; teachers and pupils need to be instructed in how to give their eyes the best chance by appropriate arrangement of the light.

"The correction of optical defects of the eye has been widely stressed and deserves all of the emphasis that has been placed upon it; but even with the optical defects exactly corrected, care and moderation need to be used for even the best eyes.

"The common causes of blindness that come with old age, like cataract and glaucoma, or hardening of the eyeball, have generally been threatening or actually progressing for years before they cause blindness. In a person of sixty-five with beginning senile cataract, it is probable that it will be fifteen years before he is unable to read and probably twenty years before he has to have the cataract removed. This time allows abundant opportunity for preventing the diseases that destroy sight in old age."

A PERTINENT QUESTION

Is it common sense to let a healthy, young mother die in childbirth at the very beginning of her productive and creative years because of *ignorance and negligence*? Motherhood is a question facing not only expectant mothers and fathers, but the community at large. Each community must recognize its responsibility in the education of its young people for the responsibilities of parenthood, so that they may know how and when and where to seek and secure adequate medical and nursing care when a baby is on the way.

What should young people know to prepare them for parenthood? There are ten simple facts which should be included in the education of every young person. Each should know that:

1. A baby lives for nine months in its mother's body before it is born.
2. An expectant mother should seek the advice of a competent doctor as soon as she *thinks* a baby is coming.
3. Throughout pregnancy the doctor should be consulted regularly so that he may be on guard for the first suggestion of beginning abnormalities.
4. When in doubt, the doctor's advice should be secured; it is better than that of friends or relatives or neighbors.
5. The mother's daily routine should be based on common-sense living—no burning the candle at both ends.
6. The responsibility for having a baby is as much the father's as the mother's; he should help his wife follow the doctor's instructions, boost her spirits when she is down, and relieve her of worry and fatiguing physical work.
7. If the baby is to be born in a hospital, a good one should be selected; approval by the American Medical Association Council on Hospitals or the American College of Surgeons is the hallmark of a good institution.
8. If the baby is to be born at home, preparations should be made in advance under the direction of the doctor or nurse.
9. The mother should remain in bed at least ten days after the baby's arrival, and should do her first mothercraft under supervision.
10. A detailed plan should be made for the baby's care before it arrives so that things will run smoothly from the very beginning.

All parents should see that their children, as they grow to maturity, know thoroughly these basic facts. If they shirk their responsibility, they are missing one of the greatest challenges which comes to a parent. It is also the responsibility of various community organizations to help train young people for parenthood. The school should endeavor to help each pupil develop a wholesome attitude toward the facts of life; the church a high moral code; the settlement houses, Boy Scouts, Girl Scouts and similar organizations a strong, sturdy character. If these important units in our society shoulder fully their responsibilities in preparing young people for parenthood, we shall find not only a reduction in our maternal deaths, but also an improvement in marital relations.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. X, No. 2, February, 1912

Special Notice:

Forty-second annual meeting of the Medical Society of the State of California.

Del Monte Hotel, Del Monte, April 16, 17, and 18, 1912.

Railroad rates the same as usual; one and one-third fare for the round trip. . . .

From Some Editorial Notes:

Owen Bill.—A number of requests for a copy of the last Owen bill to create a Department of Public Health have been received, and as the matter is of the greatest importance to public health, the *Journal*, elsewhere in this issue, prints the bill in full. It will probably be some time before the Congress will enact any law of this nature, and it is quite possible that when such a law is finally passed it will differ somewhat from the present proposed measure. . . .

Exploiters of Nostrums.—A good many of the most prominent physicians and surgeons in this country are helping to exploit and promote the use of some unspeakably noisome nostrums. Some of the "leaders of the profession"; some of those we are all in the habit of looking up to; some of the leaders in the American Medical Association, are doing just this, though they may not realize it. How? By contributing articles to so-called medical (?) or surgical (?) journals that accept the advertisement of these rotten things. . . .

Medical Defense.—Though the coöperative plan of defending our members in all actions for alleged malpractice has been in successful operation since July 1, 1909, and although, parenthetically, *no judgment has been entered against any practitioner in this State since that time*, a number of our members do not seem to understand it. For this reason, and for the reason that certain insurance companies have seen fit to make untrue remarks, it seems wise to set forth, in full, the general plan and scope of the work, rules, etc. The plan itself is the simplest form of coöperation; the members of the Society have decided that, through the machinery of the State Society, they will defend each other in all actions for malpractice that may be brought against members. To cover the cost, a small amount was added to the annual assessment, and it has been found to be ample. The rules laid down by the Council and prepared by our attorney, and subsequently approved by the House of Delegates, are about as simple as any rules could be.

First: All communications must be made to the Secretary of the State Society, Butler Building, San Francisco, California. This is in order to avoid confusion or doubt and concentrate all correspondence in one office.

Second: If a suit is threatened, do not wait for it to be filed, but notify the secretary immediately. The matter is then placed in the hands of our attorney and, as a rule, no suit is brought.

Third: Be sure that you are at all times in good standing (dues fully paid up) in your county society. Only members in good standing in a county society (and therefore in good standing in the State Society) will be defended.

Fourth: The alleged malpractice must have occurred after the first day of July, 1909, and at some time when the defendant was a member in good standing in his

(Continued in Front Advertising Section Page 14)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

Board Proceedings

The following citations have been issued returnable at the next regular meeting of the Board of Medical Examiners, to be held at Independent Foresters Hall, Los Angeles, commencing February 8, 1937:

Edward H. Anthony, alleged narcotic dereliction.
Robert V. Baker, violation of probation.
James H. Beggs, conviction, Pacific Coast Abortion Ring.
Samuel D. Burgeson, Jr., alleged narcotic dereliction.
Frank T. Cary, violation of Harrison Narcotic Act.
S. N. Chernyh, alleged narcotic dereliction.
John E. Cummings, continued from October meeting.
Merton E. Eastman, aiding and abetting unlicensed practitioner.
Thomas Flint, Jr., narcotic addiction.
Henry L. Gardner, continued from October meeting.
James Harvey Johnston, narcotic conviction.
Oscar Charles Long, violation of Harrison Narcotic Act.
Samuel C. Long, alleged illegal operation.
Thomas S. Long, use of fictitious name.
L. J. Otis, alleged narcotic dereliction.
Allen H. Peek, alleged narcotic dereliction.
Jesse C. Ross, conviction, Pacific Coast Abortion Ring.
Alfred H. V. St. John, conviction, Pacific Coast Abortion Ring.
Leo M. Schulman, alleged narcotic dereliction.
Francis W. Steddom, alleged narcotic dereliction.
William D. Teepell, fictitious name.
George E. Watts, conviction, Pacific Coast Abortion Ring.
Henry C. Wallace, narcotic violation.
C. B. Wiley, commitment.
Glen G. White, alleged illegal operation.
Edgar H. Williams, alleged narcotic dereliction.
Thomas D. Wyatt, continued from October meeting.

News

"California doctors apparently are not interested in \$200 a month positions with the State. The Personnel Board found it necessary to postpone two examinations for Civil Service positions because an insufficient number of doctors applied. One position, that of Assistant Medical Director of the State Industrial Accident Commission, is located in San Francisco, and pays \$200 per month for part-time work. The other position, as Assistant Surgeon in the Veterans' Home at Yountville, pays \$200 per month plus maintenance for the surgeon and his family." (United Press dispatch, dated Sacramento, December 28, and printed in the *San Francisco News* December 28, 1936.)

Recent inquiry came from Louisiana regarding an individual named S. H. Staples, who falsely claims to be a graduate of the University of California Medical School and to be licensed under the Medical Practice Act of California. Just another impostor!

"Roy L. Martin, fake eye doctor, who in April, 1931, fleeced Dan Carey of this county out of \$500 on a promise of a cure of eye trouble, has been arrested in Los Angeles County, but so many charges are awaiting him that it is doubtful if he will be returned here for trial. He will likely face federal charges of using the mails to defraud. Orange, Stanislaus, Riverside, and Sacramento counties are among other counties having charges against Martin. His arrest came as the result of a circular issued by

(Continued in Front Advertising Section Page 22)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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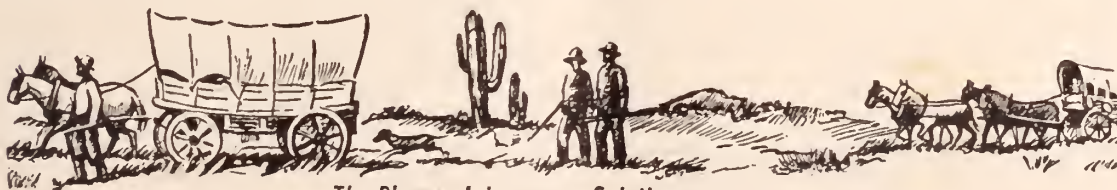


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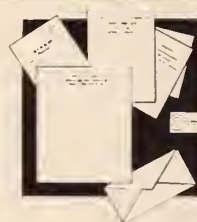
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Courts Back Up Food and Drug Administration.—Federal courts throughout the country assessed higher penalties during November than the average of the past several years, the monthly report of the Food and Drug Administration indicates. . . .

Several terminations were entered in drug cases. Lee Kelpodine Co., Inc., John Lee Clarke, and William J. A. Bailey, all of New York, "Kelpodine Tablets," consisting of compressed kelp (a seaweed), fraudulently offered for the treatment of pyorrhea, headache, indigestion, tuberculosis, cancer of the liver, glandular trouble, nervousness, dental caries, underweight, anemia, constipation, general weakness, melancholia, digestive disturbances, asthma, rickets, bone diseases, chlorosis, eczema, stomach disorders, nervous breakdown, migraine, high blood pressure, stomach ulcers, hay fever, liver congestion, subnormal growth, mental exhaustion, neurasthenia, rheumatism, arthritis, obesity, and other conditions for which the product was not a competent treatment, fine of \$100 against the company and against each individual (\$300 in all) Lee Co., Inc., and John Lee Clarke, "Kelement," a similar kelp fraud, fine \$50 each; John Lee Clarke, trading as Seavigor Co., New York, "Seavigor," still another, and similarly misbranded, fine \$200, suspended.

Tested Specialties Co., Chicago, Illinois, "On the Nose," a lard ointment, containing 15 per cent mercury, for colds, coughs, sneezes, sniffles, running nose, watery eyes, fever, loss of pep or appetite, and worms, in dogs, cats, foxes and all fur-bearing animals, was fined \$25.

Standard Chemical Co., and John W. Gamble, Omaha, Nebraska, "Fumoil," consisting of chlorinated lime, oil of eucalyptus and sulfuric acid, for colds, bronchitis, influenza, and pneumonia in poultry and hogs; "Standard Heave Powder," a mixture of calcium carbonate with small amounts of iron and sodium sulphates and phosphates and bitter plant drug, for heaves, distemper, and epizootic in horses; and, "Standard Necro Tabs," containing copper sulphate, potassium permanganate and talc, for necrotic enteritis ("necro") in hogs, were fined \$55 each (total \$110) and costs. Samuel Kovacs and Joseph Weishaus of the Royal Manufacturing Company of Du-

(Continued on Page 36)

Sleep...



NATURE'S AID IN THERAPY

FREEDOM from mental strain or nervous apprehension is often a factor of vital importance in the favorable outcome of disease or of operative procedure.

Where normal sleep is difficult, the use of hypnotics or sedatives is often indicated.

Ipral Calcium (calcium ethylisopropylbarbiturate) is a safe sedative which induces a sound, restful sleep closely resembling the normal. It is rapidly and readily absorbed, effective in small dosage and rapidly excreted. No untoward organic or systemic effects have been reported from its use and undesirable cumulative effect may be avoided by proper regulation of the dosage.

Ipral Calcium is supplied in 2-gr.

tablets and in powder form for use as a sedative and hypnotic.

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Tablets Ipral Aminopyrine (2 gr. Ipral, 2.33 gr. Aminopyrine Squibb) provide both analgesic and sedative effects.

Ipral Calcium (Powder) is available in 1-oz. bottles. Tablets Ipral Calcium, 2 gr., Tablets Ipral Aminopyrine 4.33 gr., Tablets Ipral Sodium, 2 gr. and 4 gr., and Capsules Ipral Sodium 2 gr. are available in bottles of 100 and 1000.

For literature write Professional Service Department, 745 Fifth Avenue, New York.



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(Continued from Page 34)

quesne, Chicago, Illinois, "Double D Cod Liver Oil," found not to be twice the vitamin D strength of United States Pharmacopeia cod-liver oil, and bearing extravagant therapeutic claims, fine of \$25 against each partner; Hepatin, Inc., Chicago, Illinois, "Heptuna Capsules with Vitamins A B D G," lacking in vitamin B, fine \$50; and Haarlem Research Laboratories, Inc., New York, N. Y., Superior Pharmacal Company, Dayton, Ohio, and Charles H. Dietz Company, St. Louis, Missouri, substandard pharmaceuticals, fines \$100, \$100, and \$225 and costs, respectively.

Drug products seized included one lot of substandard tincture of aconite, and seventy-two packages of gauze bandage represented as sterile or sterilized, but found on test to be contaminated with living organisms. These patent medicines were also picked up: "Beck's Little Wonder Headache Powders," each powder containing four and one-half grains of acetanilid, with caffeine and potassium citrate, represented as containing no drug of the acetanilid type, offered for sick and nervous headache, toothache, grippe, malarial headache, fever and ague, and falsely represented as "safe"; "Croup Monia Cough Syrup," containing ammonium chlorid, glycerin, alcohol, 1.3 minims chloroform per fluid ounce (the label declared 4 minims per fluid ounce) menthol, and plant extractives including pine, for coughs, hoarseness, bronchial irritations, croup, and whooping cough; "Dunlap's Antiseptic Liniment," 78 per cent alcohol (the label claimed 35 per cent) with water, chloroform, a plant extract, ammonia, oil of sassafras and oil of eucalyptus, for rheumatism, neuralgia, toothache, headache, colic, diarrhea, and cramps; "Dunlap's Colic Remedy," 51 per cent alcohol (35 per cent declared on the label), with water, ether, and small amounts of asafetida and camphor, for colic in horses and mules; "Gay," tablets, each containing two grains acetylsalicylic acid, 1.7 grains acetphenetidin and one-quarter grain caffeine, with plant material, bearing no declaration of the presence of an acetanilid derivative, and falsely represented as containing no harmful drugs and as non-habit-forming, for the relief of pain; "Lee's Creo-Lyptus," a syrup containing ammonium chlorid, alcohol and small amounts of creosote, pine tar and eucalyptol, for persistent coughs, spasmodic croup, bronchial congestion, whooping cough, tuberculosis, chronic bronchitis, pneumonia, and asthma; "Lee's Prescription," capsules, each containing 3.62 grains acetanilid, 3.52 grains acetylsalicylic acid, and caffeine, for lessening the paroxysms of hay fever and rose fever, and for sinus, grippe, running nose, weeping eyes, etc.; "Poochie Worm Remover and Conditioner," a short-weight canned article, consisting of water, oats, meat, hair, charcoal, fish oil and sodium and calcium chlorides and phosphates, represented in its labeling as containing more protein and fat than analysis disclosed, and offered as a conditioner, and for the removal of intestinal worms in dogs and cats; "Sanadon," consisting of water, sugar, guaiacol, hypophosphite, and wintergreen, falsely represented as antiseptic, and offered for the treatment and prevention of infections of the mouth, teeth, and gums, such as pyorrhea, gum ulcerations, bleeding gums, canker sores, stomatitis and sore throat, and for stopping pain, reducing inflammation and relieving soreness and bleeding; "Dr. Mary E. Stewart's Antiseptic Powder," boric acid and zinc sulphate flavored with eucalyptol and wintergreen, not antiseptic as represented, for women's ailments; and "Vacher-Balm," petrolatum with menthol and oil of eucalyptus, for catarrh, spasmodic croup, and pain.

Social Insurance Questions.—Up to now, every worker who has no dependent children and who earns 21,000 francs (about \$1,000, after devaluation of the franc) is obliged to take out social insurance. The employer pays a monthly premium equal to that paid by the worker. A worker who has two or more dependent children and who earns 25,000 francs must be insured. The government has recently proposed a law according to which these salary limits will be raised, so that a large number of workers not now insured will be obliged to join the social insurance organization. In a letter addressed by its president, Doctor Tissier, to the Federation of Medical Syndicates of France, dated August 6 and published in the Sep-

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tember issue of the *Bulletin* of the Syndicate of Physicians of the Department of the Seine, the statement is made that, although the question of raising the limit of obligatory insurance is more of an economic than of a professional character, the extension of social insurance, especially in the region of Paris, to a considerably larger number of workers cannot fail to be of interest to the practitioners of this region. The application of the social insurance law has already affected the practice of medicine seriously and imposed a heavy burden, which the profession has accepted in a most loyal manner. Confronted with the proposed modification of the law, the profession feels itself entitled to claim an application of the law which will permit a physician at least to earn a living; hence the authorities are requested to consider the present plight of the profession in France before raising the limit of obligatory insurance. No one can ignore the loss of time, the vexatious examinations, the abusive investigations to which a physician is subjected in connection with the medical control demanded by certain caisses or bureaus which pay the claims for illness of the insured. This is especially true of patients treated by the practitioner at his office or at the home of the insured. These disagreeable encounters between the medical inspectors of the caisses and the practitioners, often taking place in the presence of the patients and tending to cause them to lose confidence in their medical attendant, should in the future be avoided in the case not only of those already insured but also, if the proposed limit is raised, of those in the higher salaried brackets, who are more likely to consult a physician than those in the present lower brackets. The original law of 1930 had given the insured workers and their medical attendants a certain number of guaranties, such as free choice of physicians and the equitable adjustment of indemnities, which has induced the majority of the working class to accept the law. The law as modified in October, 1935, which was not passed on by the legislature, added a number of restrictions, which have increased the power of the caisses or disbursing bureaus. The regional boards on which the organized medical profession is represented are seldom summoned to meet with the superior

council of the social insurance organizations. The secretary of the Federation, in his answer to this letter, stated that most of the abuses to which the local (Seine) organization had directed attention were only in the power of the main social insurance organization and its subsidiaries to correct. As to the higher limit of obligatory insurance, this will not go into effect, as proposed in the recent bill.—*Foreign Letters, J. A. M. A.*

A Commission to Study Hospital Lotteries.—The government of South Australia appointed a royal commission to inquire whether it is desirable to institute lotteries in South Australia for the purpose of raising funds to assist in the finance of hospitals and other charitable institutions. The Commission took evidence in the different states of commonwealth and had special statistical information about lotteries of Great Britain, Ireland, France, the United States, and Canada. The Commission expressed itself in its report as being not unduly influenced by the religious or ethical aspect. It says it would not have felt justified in coming to its conclusion or objecting to the lottery system on the ground of ethical objection, if on other grounds it had been found desirable. There is a real difference in principle between a government on the one hand taxing private betting or other private activities of the people and on the other hand introducing a lottery for the purpose of raising money for one of its essential social services. In the former case the Government takes no part in the promotion of the activities on which the tax is levied. In the case of a lottery, Parliament either directly or through a department established by it, promotes the lottery for the purpose of profit and takes an active part in inducing people to subscribe to it. No Australian government urges people by advertisement to bet on horse races in order that more revenue may be obtained from betting, or to go to the pictures so that the amusement-tax revenue may be increased, but when there are lotteries the public is definitely encouraged to do so.

(Continued on Next Page)

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(Continued from Preceding Page)

The Commission was much impressed in the course of its investigations by what appeared to be the political repercussions of lotteries either conducted by governments or under a government license. The Commission gained the definite impression that lotteries conducted on the lines of those of New South Wales, Queensland, and Tasmania, tend to become the masters rather than the servants of the government that "controls" them. The Commission considered that the state of affairs tends to demoralize governments. After full and careful investigation the Commission satisfied itself that the lottery does not and cannot solve the hospital finance problem. Even in Ireland the immense Irish sweep has not relieved the Government or the local authorities of their hospital obligations, and in Western Australia and in Queensland lotteries have not helped the Government to any material extent. The existence of lotteries in four of the six Australian states, and the seeming benefits derived from them, give an impression that a lottery is desirable. After thorough investigation, however, the Commission is satisfied that these benefits are more superficial than real.

It may appear difficult to understand why it is that, with all the revenue that lotteries bring in, the Government or local authorities do not secure corresponding relief. There are several contributing factors to this position: (1) The people of Australia are becoming more and more hospital-minded, which means an increasing demand for accommodation. (2) The existence of a lottery tends to create in the people a demand as of right for a much higher standard of hospital buildings and equipment, and for more hospitals. (3) The practice has been generally to use lottery moneys for capital expenditure and, therefore, the cost of maintenance necessarily increases. (4) The existence of a lottery tends to decrease the voluntary contributions for hospital and charitable purposes, and this factor is greatly accentuated when there is a rate or tax for hospitals as well. (5) Where charities are associated with lotteries, the charitable institutions set up higher standards. (6) It may be that one of the reasons why

lottery moneys are spent in the manner in which they are is that such expenditure provides an excellent advertisement for the lottery. For these reasons the Commission found that the establishment of a lottery will not materially relieve the Government or the local governing authorities of their burdens for hospitals or charities. In fact, because of the higher standard that is built up through the expenditure of lottery moneys as capital the ultimate burden is likely to be increased by the existence of a lottery.

Everywhere, says the report, there is a tendency to increase the prizes, and especially the first prize; and everywhere the lottery is an exploitation of the gullibility of the public and the widespread gambling instinct. In fact, so deep-seated has this legalized form of gambling become that it is doubtful whether any government would dare to introduce legislation to abolish these lotteries. The Commission concluded that a lottery as a form of hospital finance provides an unstable method that is demoralizing to the Government, distinctly injurious to traders, and detrimental in the end to the poorer sections of the community, who contribute the bulk of the receipts. If the people who buy lottery tickets can easily afford the money, they can afford to pay their share of the direct taxation necessary to support hospitals. If they cannot afford the money, the state should not take their money. From the establishment of the "golden casket" in Queensland nearly twenty years ago the total receipts amounted to £12,000,000, the prize money amounted to £7,000,000 and the sum paid to hospitals and charities after payment of expenses was £3,000,000. These figures confirm the Commission in its belief that the lottery does not and cannot solve the hospital finance problem and, consequently, it was recommended that the practice should not be permitted in South Australia.—J. A. M. A.

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Medical Bills in Congress.—Bills Introduced: S. 5, introduced by Senator Sheppard, Texas, for Senator Cope-land, New York, and H. R. 300, introduced by Representa-tive Chapman, Kentucky, propose to prevent the adultera-tion, misbranding and false advertising of food, drugs, devices and cosmetics in interstate, foreign and other com-merce subject to the jurisdiction of the United States. S. 6, introduced by Senator Lundeen, Minnesota, proposes to provide for a nation-wide system of social insurance. A social insurance fund is to be created by an appropri-ation of \$5,000,000,000, from which compensation is to be paid to unemployed, aged or disabled workers. A worker is to be considered disabled if by reason of any physical or mental condition, sickness or handicap he is rendered incapable of total or partial work in his usual or in a suitable occupation, irrespective of fault and irrespective of whether such a disability is the result of accident, illness, disease, physical or mental handicap, or other causes. S. 123, introduced (by request) by Senator Robinson, Ar-kansas, proposes to authorize an appropriation of \$5,000,000 to enable "each state to provide and operate at least one hospital bed for tubercular patients to each annual death from tuberculosis." S. 325, introduced by Senator Hatch, New Mexico, proposes to prohibit the shipment and trans-portion in interstate or foreign commerce of cannabis and its derivatives and compounds, except when shipped or transported for medical and legitimate uses by the pro-ducer, manufacturer or dealer to licensed physicians, sur-geons, dentists, pharmacists, druggists, and veterinarians, under such rules and regulations as shall be prescribed by the Commissioner of Narcotics. A similar bill in the House, H. R. 229, introduced by Representative Fish, New York, proposes to amend the Narcotic Drugs Im-port and Export Act to provide that no cannabis indica, cannabis sativa, or cannabis americana may be imported for the purpose of making marihuana, or for any other purpose. H. R. 119, introduced by Representative Beiter, New York, proposes to extend the benefits of the United States Public Health Service to certain seamen. H. R. 136, introduced by Representative Cochran, Missouri, pro-poses to authorize the Reconstruction Finance Corporation

to make loans to any public or private hospital organized under the laws of any state on the same terms and con-conditions that are applicable in the case of loans to financial institutions. H. R. 216, introduced by Representative Lemke, North Dakota, proposes to authorize the erection of an addition to the existing Veterans' Administration facility, Fargo, North Dakota, such addition to consist of one hundred beds for the care and treatment of general medical and surgical disabilities. H. R. 279, introduced (by request) by Representative Celler, New York, pro-poses to enact a "Workers' Unemployment and Social Insurance Act" and to direct the Secretary of Labor to establish forms of social insurance to pay workers and farmers for loss of wages because of part-time work, sick-ness, accident, old age, or maternity. H. R. 1555, intro-duced by Delegate Dimond, Alaska, proposes to authorize the Secretary of the Interior to establish a hospital for the insane of Alaska. H. R. 1560, introduced by Delegate Dimond, Alaska, proposes to extend the benefits of the United States Public Health Service to any person oper-ating or employed on board certain vessels engaged in fishing operations. H. R. 1952, introduced by Representa-tive Buchanan, Texas, proposes to include the name of Roger P. Ames among those honored by the act recog-nizing the service rendered by Major Walter Reed in the discovery of the cause and means of transmission of yellow fever. H. R. 1962, introduced by Representative Secrest, Ohio, proposes to establish a Bureau of Veterans' Affairs in the Department of the Treasury with the Com-missioner of Veterans' Affairs at the head thereof, to abolish the Veterans' Administration and to transfer its functions to such bureau, to adjust and equalize pensions of veterans and widows and dependents of veterans and for other purposes.—J. A. M. A.

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Accident Insurance: "Death Resulting From Accidental Suffocation by Gases" Construed.—The defendant insurance company issued to the insured two accident insurance policies in which it promised to pay certain benefits in case the insured died, but limited liability to \$600 in event of "death resulting from accidental suffocation by illuminating or other gases or the accidental taking of any poison." Three days after the policies were issued, the insured was found in his garage overcome by the fumes escaping from the motor of his automobile. He died a few minutes later from carbon monoxid poisoning. The defendant claimed that the death resulted "from accidental suffocation by illuminating or other gases" and that therefore it was liable only to the extent of \$600. The plaintiff, the beneficiary under the policies, brought suit to recover the maximum benefits. The trial court sustained the defendant's motion to withdraw from the jury the question of liability over and above \$600 and, with the consent of the defendant, entered a judgment for the plaintiff for that amount. The plaintiff thereupon appealed to the Supreme Court of Nebraska.

It was not disputed, said the court, that the insured died as a result of his inhaling the fumes from the exhaust of his automobile. That the death was, therefore, caused by the inhalation of gas cannot be denied. In *Birss vs. Order of United Commercial Travelers*, 109 Neb. 226, 190 N. W. 486, it was said:

"The term 'gas' is, in a sense, a generic term and is broad and sweeping in its meaning. In Webster's Unabridged Dictionary it is defined as 'an aeriform fluid; a term used at first by chemists as synonymous with air, but since restricted to fluids supposed to be permanently elastic, as oxygen, hydrogen, etc., in distinction from vapors, as steam, which become liquid on a reduction of temperature. In present usage, since all of the supposed permanent gases have been liquefied by cold and pressure, the term has resumed nearly its original signification, and is applied to any substance in the elastic or aeriform state.'"

The contention of the beneficiary was that death had not resulted from accidental suffocation, relying apparently on medical testimony to the effect that inhaled carbon monoxid gas does not stay in the lungs and does not, therefore, act as a mechanical barrier to respiration. Death results when there is sufficient concentration of carbon monoxid combined with the hemoglobin or red blood cells to displace the oxygen. But, said the court, in construing the contract of insurance, words used therein will be considered as used in their ordinary and popular sense. The definitions or constructions placed on them by the scientist or expert cannot control. "Suffocate," continued the court, is defined in Webster's New International Dictionary as "to kill by stopping respiration, as by strangling or asphyxiation," while the same authority defines "asphyxiation" as "a state of asphyxia; suffocation," and "asphyxia" as "apparent death, or suspended animation, in living organisms, due to deficiency of oxygen and excess of carbon dioxide, specif., in the blood, as in interruption of respiration from suffocation or drowning, or from the inhalation of irrespirable gases." "Suffocation" is defined in Dorland's American Illustrated Medical Dictionary (ed. 16) as "the stoppage of respiration, or the asphyxia that results from it," while the same authority defines "asphyxia" as "suffocation; also suspended animation from suffocation or a deficiency of oxygen in the blood."

In view of these definitions, the court was convinced that a person suffers death as the result of suffocation by gas whether death was due to a deficiency of oxygen in the blood or to an interruption of the physical act of breathing

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that would prevent the inhalation of sufficient oxygen into the lungs. The judgment of the trial court for the plaintiff for the limited benefits provided in the policies was, therefore, affirmed. (*Stone vs. Physicians Casualty Assn. of America* (Neb.), 266 N. W. 605).—J. A. M. A.



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Closing of Houses of Prostitution.—Many foreigners who have visited France, and especially Paris, will be surprised to hear that Mr. Sellier, the present Secretary of Public Health, proposes in the near future not only to close licensed houses of prostitution and to restrict occupancy of hotel rooms to those who have baggage, but also to make the acquisition of syphilis a criminal offense and its treatment obligatory. In an article in the November 15 *Sécle médical*, Dr. Léon Bizard protested against this policy of Mr. Sellier. Doctor Bizard is well qualified to discuss this question, being one of the staff of the St. Lazare Hospital, to which all prostitutes are obliged to go for the treatment of venereal diseases. There are 1,200 "tolerated" houses of prostitution in France and its colonies. The Secretary of Public Health believes that syphilis can be conquered if the houses of prostitution are closed, that the white slave traffic will cease, and that the landlords of the dens of vice will be ruined. Bizard remarks that this plan of freeing the people from sinful

habits and leading them back to the path of virtue is a magnificent one, but that there will soon be a rude awakening to the impossibility of the execution of such a plan. The innumerable hotels, according to the proposed law, will not be permitted to rent rooms to couples without baggage. Bizard remarks that this can be easily circumvented by renting adjacent rooms or perhaps, as he states, there will be created a new trade as now exists in the United States, namely, that of "renting baggage" for a small fee. There will still remain, for those able to pay a higher sum, houses of assignation. The closing of "tolerated" houses will result in increase of street soliciting, which will render control of venereal diseases more difficult than at present, when the inmates of the "tolerated" houses are examined twice a week by medical inspectors of the police departments. The existing system of "segregation," with its strict control, will be superseded by that of "scatteration" and less perfect medical supervision, so that the number suffering from venereal diseases will be greater than at present. Bizard pleads for an amelioration instead of suppression of "tolerated" houses, citing measures taken in Italy, which has prohibited street soliciting but allowed "tolerated" houses to exist without any special signs or lights indicating the character of their trade. Such a plan will do more to check venereal diseases than that of forcing prostitutes to go on the streets.—*J. A. M. A.*

Dedication of Eastman Dental Clinic in Paris.—Work has progressed so rapidly on the million-dollar Eastman Dental Clinic, now under construction in Paris, that Dr. Harvey J. Burkhart, director of the Rochester Dental Dispensary and general administrator of the Eastman Foundation, announced recently that it is hoped to finish the entire building in time to hold the dedication ceremonies on July 4, 1937. The president of the French Republic, Mr. Lebrun, Ambassador William C. Bullitt,

(Continued on Page 44)

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Karo	2 tablespoons

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Boiled Water	20 ounces
Karo	2 tablespoons

Lactic Acid Milk	12 ounces
Boiled Water	8 ounces
Karo	2 tablespoons

References: Kugelmass, Clinical Nutrition in Infancy and Childhood, Lippincott; Marriott, Infant Nutrition, Mosby; McClean & Fales, Scientific Feeding in Infancy, Lea & Febiger.

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POWELL at SUTTER



(Continued from Page 42)

and a number of other leading French and American personalities will be invited to take part in the ceremonies. The clinic was designed to provide free dental service for children less than sixteen years of age who are unable to pay. The clinic occupies a large area, and the open land surrounding the clinic will be converted into parks and playgrounds. The work of the Paris Eastman Clinic will be based on that carried out at Rochester, and it should serve as a center for dentists and dental surgeons to carry on research and postgraduate work. It will also aim to teach children and parents the need and value of regular dental work throughout their lives.—J. A. M. A.

Feeding the Dionne Quintuplets.—The January *Journal of the Canadian Medical Association* contains a detailed account of Dr. Allen Roy Dafoe, of his management of the famous Dionne Quins, during the first year of their lives.

They were kept in incubators until each one reached the weight of six pounds.

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On the first day they were given, every two hours, ten or fifteen drops of warm water with an eye dropper. Every two hours, on the second and third days, each had from thirty to sixty drops of a mixture containing seven ounces of milk, thirteen ounces of water, and one ounce of corn syrup.

From the fourth day until October 19, they were kept on breast milk. They were then placed on a mixture of

cow's milk and Dextri-Maltose. After a few days evaporated milk was substituted for cow's milk with the addition of lacto-bacillus acidophilus.

This formula was used until the children were one year old.

At the second month they were given vitamin D in the form of viosterol.

The first solid food was used on October 26 in the form of Pabulum, which was given daily from that date.

Assorted vegetables and fruits cooked and strained were also used in the diet.

The nutritional improvement in the children was satisfactory throughout.

Their management by Doctor Dafoe reflects great credit on his professional skill.

The world justly applauds him on his success.

Entire Freedom From Tuberculosis of Cattle, Is United States Aim.—With the continued coöperation of public officials, veterinarians, livestock owners, and others who have aided in the aggressive fight against bovine tuberculosis, leaders in the work hope that eventually this disease will be entirely eradicated. In forty-three states the prevalence of bovine tuberculosis has already been reduced to less than one-half of one per cent. These developments were the basis of an address by Dr. John R. Mohler, Chief of the United States Bureau of Animal Industry, at an Achievement Day celebration at Harrisburg, Pennsylvania. The event celebrated federal recognition of Pennsylvania as a modified accredited area, signifying the reduction of bovine tuberculosis throughout the state to less than one-half of one per cent. . . .

Medicine is as old as the human race; as old as the necessity for the removal of diseases.—Heinrich Haeser.

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Malpractice: Liability of Physician for Abandonment of Patient.—The defendant, a physician, was engaged to attend the plaintiff during the latter part of her pregnancy. Prior to her confinement she had a "hemorrhage," the date of which is not given in the record. About three weeks thereafter, in the early afternoon, she had another "hemorrhage" and the defendant was called and attended her at her home. The patient continued to lose blood and to suffer pain, and at midnight the defendant again responded to a call. Shortly after eight o'clock the following morning the defendant, at the behest of the plaintiff's husband, called on the patient and found her still bleeding and in severe pain. Arrangements were immediately made to transfer the patient, in an ambulance, to a hospital. The defendant did not accompany the patient. On her arrival at the hospital she was cared for by nurses, who "gave her pills, injections, and so on." Later two physicians, apparently at the instance of the hospital authorities, attended the plaintiff. During this time the plaintiff's husband and others made repeated attempts by telephone to get in touch with the defendant, but he could not be located. He did not appear at the hospital until three o'clock that afternoon, either just before or after the plaintiff gave birth to a child that did not survive. In a suit subsequently instituted by the plaintiff against the defendant, she alleged that he was guilty of a breach of his professional duty in that he neglected to accompany her to the hospital, failed to be present during her labor and childbirth, and failed to render such treatment as would have stopped her bleeding and insured the delivery of a living child. She sought recovery of damages for pain which she had suffered and would continue to suffer, and for great mental and physical anguish caused by her having given birth to a dead child. The trial court directed a verdict for the physician and, from the judgment entered on that verdict, the plaintiff appealed to the Supreme Court of Michigan.

The Supreme Court did not pass on the plaintiff's contention that she was legally entitled to the personal care

(Continued on Page 47)



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and attendance of the defendant. It did say that the evidence showed that, through the defendant's arrangements for her removal to the hospital, she had received professional care and attention and that there was no competent testimony that the defendant's failure to attend her in person resulted in her suffering any greater pain than she otherwise would have suffered, or that the unfortunate outcome of her confinement was caused by his absence. Furthermore, in the opinion of the court, the record failed to show that the defendant by proper care could have and should have caused cessation of her hemorrhages. In short, the plaintiff failed to show, the court concluded, that she would have suffered less or that she would have escaped any of the elements of damages for which she sought recovery had the defendant attended her in person during the interval he was absent instead of causing her to be placed under the care of other skilled persons. The judgment for the defendant was affirmed. (*Jackowicz vs. Knobloch* (Mich.), 265 N. W. 799.—*J. A. M. A.*)

Victory and Defeat.—However large or small our part, we can all feel with Theodore Roosevelt, who said: "It is not the critic who counts; not the man who points out how the strong man stumbled, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena; whose face is marred by dust and sweat and blood; who strives valiantly; who errs and comes short again and again; who knows the great enthusiasms, the great devotions, and spends himself in a worthy cause; who at the best knows in the end the triumphs of high achievement; and who at the worst, if he fails, at least fails while daring greatly; so that his place shall never be with those cold and timid souls who know neither defeat nor victory."

"Negligence, indifference, ignorance, and false economy—not the Lord—make the death rate high."



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Butte County Medical Society President, John H. White, 315 Wall Street, Chico. Secretary, J. O. Chiapella, 131 Broadway, Chico. Meeting, <i>Second Thursday.</i>	Napa County Medical Society President, Fred Heegler, Migliavacca Building, Napa. Secretary, M. M. Booth, Bruck Building, St. Helena. Meeting, <i>First Wednesday.</i>	Santa Barbara County Medical Society President, Irving Wills, 1421 State Building, Santa Barbara. Secretary, William H. Eaton, 822 De la Guerra Terrace, Santa Barbara. Meeting, <i>Second Monday, Cottage Hospital.</i>
Contra Costa County Medical Society President, Clara H. Spalding, 331 Eighth Street, Richmond. Secretary, Thomas J. Dozier, 202 G Street, Antioch. Meeting, <i>Second Tuesday, 8 p. m.</i>	Orange County Medical Society President, John D. Ball, 414 Spurgeon Building, Santa Ana. Secretary, Glenn Curtis, 323 So. Pomona Street, Brea. Meeting, <i>First Tuesday, 8 p. m., Chapel of the Orange County Hospital, Orange.</i>	Santa Clara County Medical Society President, R. Stanley Kneeshaw, 404 Medico-Dental Building, San Jose. Secretary, Leslie B. Magoon, Medico-Dental Building, San Jose. Meeting, <i>Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.</i>
Fresno County Medical Society President, J. M. Frawley, T. W. Patterson Building, Fresno. Secretary, O. B. Doyle, Bank of America Building, Fresno. Meeting, <i>First Tuesday, University-Sequoia Club, Fresno.</i>	Placer County Medical Society President, C. E. Lewis, 59 Lincoln Ave., Auburn. Secretary, Robert A. Peers, Colfax. Meeting, <i>At Call of President.</i>	Santa Cruz County Medical Society President, A. N. Nittler, 36½ Pacific Avenue, Santa Cruz. Secretary, Samuel B. Randall, Farmers and Merchants Bank Building, Santa Cruz. Meeting, <i>Second Tuesday, 7:30 p. m., Hotel Rio del Mar, Aptos.</i>
Humboldt County Medical Society President, Allan R. Watson, 350 E Street, Eureka. Secretary, Lawrence A. Wing, Fifth and F Streets, Eureka. Meeting, <i>First Thursday.</i>	Riverside County Medical Society President, H. L. Ratliff, 3616 Main Street, Riverside. Secretary, Thomas A. Card, 3616 Main Street, Riverside. Meeting, <i>Second Monday, 8 p. m., Library, Riverside Community Hospital.</i>	Shasta County Medical Society President, Oscar J. Hansen, 318 Yuba Street, Redding. Secretary, Leslie J. Seeley, 1432 York Street, Redding. Meeting, <i>Second Monday.</i>
Imperial County Medical Society President, Floyd A. Burger, Box 193, El Centro. Secretary, Merritt C. Canfield, 204 Professional Building, El Centro. Meeting, <i>Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.</i>	Sacramento Society for Medical Improvement President, Raymond M. Wallerius, 312 Physicians Building, Sacramento. Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento. Meeting, <i>Third Tuesday, 8:30 p. m., Auditorium, Sacramento.</i>	Siskiyou County Medical Society President, E. F. Carlson, Fort Jones. Secretary, J. B. Maguire, Mt. Shasta City. Meeting, <i>Second Sunday.</i>
Kern County Medical Society President, H. R. McAllister, Professional Building, Taft. Secretary, C. S. Compton, 428 C Street, Bakersfield. Meeting, <i>Third Thursday, 8:30 p. m.</i>	San Benito County Medical Society President, L. C. Hull, Hollister. Secretary, L. E. Smith, Hollister. Meeting, <i>At Call of President.</i>	Solano County Medical Society President, H. Brownlie Perkins, 445 Georgia Street, Vallejo. Secretary, John W. Green, Box 539, Vallejo. Meeting, <i>Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.</i>
Kings County Medical Society President, P. K. Edmunds, Corcoran. Secretary, William A. Johnstone, Hanford. Meeting, <i>On Call.</i>	San Bernardino County Medical Society President, D. C. Mock, 215 Cajon Street, Redlands. Secretary, A. E. Varden, Medico-Dental Building, San Bernardino. Meeting, <i>First Tuesday, 8 p. m., San Bernardino County Charity Hospital.</i>	Sonoma County Medical Society President, C. B. Andrews, Sonoma. Secretary, C. M. Carlson, 1055 Fourth Street, Santa Rosa. Meeting, <i>Second Thursday.</i>
Lassen-Plumas-Modoc County Medical Society President, C. I. Burnett, Susanville. Secretary, Fred J. Davis, Jr., Westwood. Meeting, <i>On Call.</i>	San Diego County Medical Society Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego President, S. J. McClendon, 2001 Fourth Street, San Diego. Secretary, W. H. Newman, Medico-Dental Building, San Diego. Meeting, <i>Second Tuesday, El Cortez Hotel.</i>	Stanislaus County Medical Society President, Marion C. Collins, Turlock. Secretary, Edwin F. Hagedorn, Box 834, Modesto. Meeting, <i>Second Friday.</i>
Los Angeles County Medical Association 1925 Wilshire Boulevard, Los Angeles President, John P. Nuttall, 203 Professional Building, Santa Monica. Secretary, E. Vincent Askey, 1925 Wilshire Boulevard, Los Angeles. Meetings, <i>First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.</i>	San Francisco County Medical Society 2180 Washington Street, San Francisco President, T. Henshaw Kelly, 490 Post Street, San Francisco. Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco. Meetings, <i>Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.</i>	Tehama County Medical Society President, Donald E. Thompson, Red Bluff. Secretary, F. J. Bailey, Red Bluff. Meeting, <i>At Call of President.</i>
Marin County Medical Society President, Anne L. Brady, Albert Building, San Rafael. Secretary, Carl W. Clark, 510 B Street, San Rafael. Meeting, <i>Fourth Thursday, 6:30 p. m., Marin Golf and Country Club.</i>	San Joaquin County Medical Society President, John S. Blinn, 1101 Medico-Dental Building, Stockton. Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton. Meeting, <i>First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.</i>	Tulare County Medical Society President, J. C. McClure, Lindsay. Secretary, Karl F. Weiss, Security First National Bank Building, Visalia. Meeting, <i>Sunday Evening once a month.</i>
Mendocino-Lake County Medical Society President, J. J. Kirwin, Ukiah. Secretary, Thomas P. Hill, Lakeport. Meeting, <i>On Call.</i>	San Luis Obispo County Medical Society President, Charles R. Kennedy, Bank of America Building, Paso Robles. Secretary, E. D. Anderson, 1120 Morro Street, San Luis Obispo. Meeting, <i>Third Saturday, 6:30 p. m., Mulholland's Grill, San Luis Obispo.</i> (Roster lists continued on advertising page 6)	Ventura County Medical Society President, F. R. Hendricks, 885 East Main Street, Ventura. Secretary, A. A. Morrison, 625 Main Street, Santa Paula. Meeting, <i>Second Tuesday, Ventura County Country Club.</i>
Merced County Medical Society President, Max Brannon, Merced. Secretary, Fred O. Lien, Shaffer Building, Merced. Meeting, <i>Third Thursday, Hotel Tioga, Merced.</i>	Yolo-Colusa-Glenn County Medical Society President, Stanley E. Coffey, 239 Fourth Street, Orland. Secretary, Ray E. Nichols, Woodland. Meeting, <i>First Tuesday.</i>	Yuba-Sutter County Medical Society President, Stanley R. Parkinson, 434 Fourth Street, Marysville. Secretary, Fred W. Didier, Wheatland. Meeting, <i>Second Tuesday.</i>

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The Public Health League of California		
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VITAMIN REQUIREMENTS OF MAN

I. VITAMIN C.

• Vitamin C is known to play an important role in human nutrition. Severe deficiency of this factor results in scurvy. It has been estimated by the Committee on Nutritional Problems of the American Public Health Association (1934) that the minimum daily intake of vitamin C (cevitamic acid) required to protect against scurvy increases from approximately 100 International units (5 mg. cevitamic acid) for the infant to 300 International units (15 mg. cevitamic acid) for the adult (1).

Vitamin C intake of this order of magnitude prevents the development of clinical scurvy, however, it is probably inadequate for optimum nutrition. Clear cut cases of scurvy seldom are seen in this country although some authorities believe that symptoms of a mild deficiency of vitamin C are not uncommon (2).

Referring to nutritional deficiency diseases in general it has been said that, "Almost every tissue in the body may be affected by a deficiency in a food factor" (3).

The tissues generally recognized as affected by deficiency of vitamin C are the endothelium of the blood vessels and the teeth. It has been suggested that to prevent the development of subclinical symptoms, a daily intake of 380 to 540 International units of vitamin C is required for a 130 pound adult (4).

Thus it would appear that the optimum in-

take of vitamin C is at least twice the amount required to protect against scurvy.

Data recently published demonstrate that the vitamin C content of human milk is dependent upon the vitamin C content of the maternal diet (5).

Hence when the diet of the lactating mother is low in vitamin C, this factor is also deficient in the milk.

The League of Nations Technical Commission recommends an intake of over 500 International units per day during pregnancy and lactation (6).

The inclusion in the diet of liberal quantities of fruits and vegetables, prepared in such a manner as to retain a major portion of the original vitamin C content, may be relied upon to supply the need for this vitamin. The value of commercially canned foods as anti-scorbutics has been repeatedly demonstrated during the past decade (7).

More recently, the vitamin C content of many commercially canned fruits and vegetables has been determined and the results expressed in International units (8).

Consideration of two factors, namely, the quantitative requirement of the human for vitamin C, and the vitamin C potencies of commercially canned fruits and vegetables, emphasizes the value of these protective foods as sources of vitamin C.

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230 Park Avenue, New York City

- (1) 1934-35. Am. Pub. Health Assn. Year Book. Page 71
(2) 1933. Chemistry of Food and Nutrition. H. C. Sherman. 4th Ed. Page 421 MacMillan, New York

- (3) 1936. J. Am. Med. Assn. 106, 261
(4) 1934. Nature 134, 569
(5) 1936. J. Nutrition 11, 599

- (6) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.

- (7) a. 1925. Ind. Eng. Chem. 17, 69
b. 1928. Ibid. 20, 202
c. 1933. Ibid. 25, 682
(8) a. 1935. J. Nutrition 9, 667
b. 1936. Ibid. 11, 383
c. 1936. Ibid. 12, 405

This is the twenty-second in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

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COLFAX SCHOOL FOR THE TUBERCULOUS For the Treatment of Tuberculosis Colfax, California	LIVERMORE SANITARIUM Nervous and General Diseases Livermore, California	ST. LUKE'S HOSPITAL Limited General Hospital 27th and Valencia Streets, San Francisco
COMPTON SANATORIUM AND LAS CAMPANAS HOSPITAL Neuropsychiatric and General Compton, California	OAKS SANITARIUM For Treatment of Tuberculosis Los Gatos, California	ST. MARY'S HOSPITAL General Hospital 2200 Hayes Street, San Francisco
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BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

Inhalation Anesthesia. A Fundamental Guide. By Arthur E. Guedel, M. D., Associate Clinical Professor of Surgery (Anesthesia) University of Southern California School of Medicine. Cloth. Pp. 172. Price, \$2.50. New York: The Macmillan Company, 1937.

The Colon as a Health Regulator—From a Surgeon's Point of View. The Effects and Treatment of Its Developmental Abnormalities. By Sir Henry M. W. Gray, K. B. E., C. B., C. M. G., LL. D. (Aberdeen), M. B., C. M. (Aberdeen), F. R. C. S. (Edinburgh), etc., Colonel A. M. S. (Retired), Late Consultant Surgeon, B. E. F., France and Consultant in Special Military Surgery (orthopedic), Home Service, etc. Cloth. Pp. 100, illustrated. Price, \$2.50. Toronto: The Macmillan Company of Canada, Limited, at St. Martin's House, 1936.

A Handbook of Ocular Therapeutics. By Sanford R. Gifford, M. A., M. D., F. A. C. S., Professor of Ophthalmology, Northwestern University Medical School, Chicago, Illinois; Attending Ophthalmologist, Passavant Hospital, Wesley Memorial Hospital, Evanston Hospital, Cook County Hospital. Second Edition, Thoroughly Revised. Cloth. Pp. 341, illustrated with sixty engravings. Philadelphia: Lea & Febiger, 1937.

Nostrums and Quackery and Pseudo-Medicine. By Arthur J. Cramp, M. D., Formerly Director of the Bureau of Investigation (1906-1936) of the American Medical Association. With a Foreword by George H. Simmons, M. D., LL. D., Editor and General Manager Emeritus, American Medical Association. Volume III. Cloth. Pp. 232. Price, \$1.50. Chicago: Press of American Medical Association, 1936.

Physical Diagnosis. By Ralph H. Major, M. D., Professor of Medicine in the University of Kansas. Cloth. Pp. 457, with 427 illustrations. Price, \$5 net. Philadelphia: W. B. Saunders Company, 1937.

Carcinoma of the Female Genital Organs. By M. C. Malinowsky and E. Quater. Translated from the Russian by A. S. Schwartzmann, A. B., M. D. Cloth. Pp. 255, illustrated. Price, \$5. Boston: Bruce Humphries, Inc., 1936.

Annual Report of the Surgeon-General of the Public Health Service of the United States for the Fiscal Year 1936. Cloth. Pp. 158. Price, \$1. Washington: United States Government Printing Office, 1936.

(Continued on Next Page)

NEW MEDICAL BOOKS

Bridges: Dietetics for the Clinician . . .	\$10.00
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Gifford: Ocular Therapeutics, 2nd Ed. . .	3.75
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BOOKS RECEIVED

(Continued from Preceding Page)

United States Naval Medical Bulletin. Published Quarterly for the Information of the Medical Department of the Navy. Issued by the Bureau of Medicine and Surgery, Navy Department. Division of Publications, Commander Louis H. Roddis, Medical Corps, U. S. Navy, in Charge. Volume 35, No. 1, January, 1937. Paper. Pp. 155. Price, 25 cents. Washington: United States Government Printing Office, 1937.

The Arbitration Journal. Published by the American Arbitration Association in Collaboration with the Chamber of Commerce of the State of New York, and the Inter-American Commercial Arbitration Commission. Volume 1, No. 1, January, 1937. Paper. Pp. 113. Price, 60 cents.

Autopsy Diagnosis and Technique. A Manual for Medical Students, Practitioners, Pathologists, and Coroners' Physicians. By Otto Saphir, M. D., Chairman of Nelson Morris Institute for Medical Research; Pathologist, Michael Reese Hospital; Associate Professor of Pathology, University of Illinois Medical School, Chicago. Foreword by Ludvig Hektoen, M. D. Cloth. Pp. 342, with sixty-five illustrations. Price, \$5. New York: Paul B. Hoeber, Inc., 1937.

BOOK REVIEWS

Physical Diagnosis. By Ralph H. Major, M. D., Professor of Medicine in the University of Kansas. 457 pages, with 427 illustrations. Philadelphia and London: W. B. Saunders Company, 1937. Cloth, \$5 net.

The author impels interest and confidence in this new text. The book is a summary of his fifteen years' experience as a teacher, which enhances its value. It is a text on diagnosis, indicating the paths of observations and examination and enabling the examiner to draw conclusions that diagnosis may be based upon.

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Well written, well selected illustrations, concise but still ample description, it is a succinct text. Nothing more need be said.

Carcinoma of Female Genital Organs. By M. C. Mallnowsky and E. Quater. Translated from Russian by A. S. Schwartzmann, M. D. Pp. 250. Price, \$5.00. Boston: Bruce Humphries, Inc.

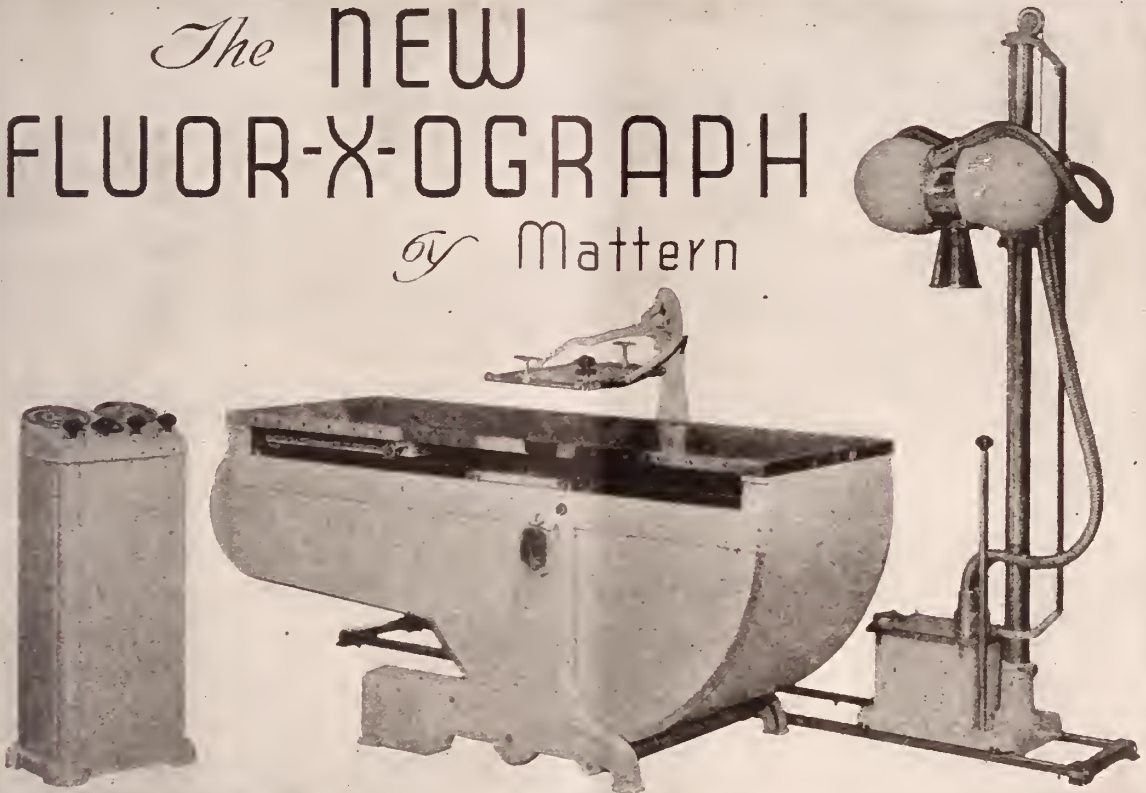
A discussion of the subject of carcinoma in somewhat extended detail and consistent with present knowledge. No noteworthy addition is made to the literature.

Inhalation Anesthesia. By Arthur E. Guedel, M. D., University of Southern California. Pp. 172. Price, \$2.50. New York: The Macmillan Company.

A fundamental guide based on personal and war experiences. It should serve as an excellent helper to the individual beginning in the field of the administration of anesthetics. It gives a sound foundation upon which to develop experience and attain ability.

(Continued on Page 17)

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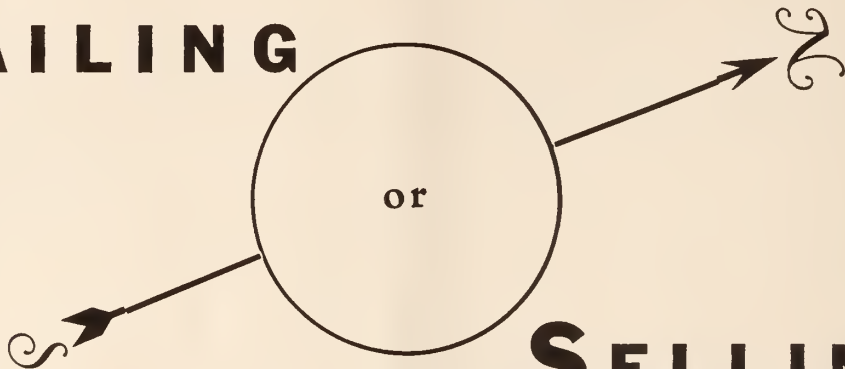
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BOOK REVIEWS

(Continued from Page 14)

The Colon as a Health Regulator. By Sir Henry M. W. Gray, Aberdeen. Pp. 100. Price, \$2. New York: The Macmillan Company.

Setting forth the author's personal views upon the function of the colon and its influence on health. Nothing new or important is advanced.

Handbook of Ocular Therapeutics. Second Edition. By Sanford R. Gifford, M. A. M. D., Northwestern University. Pp. 340. Philadelphia: Lea & Febiger.

This second edition is an improvement, brought up to date by additions on vitamins, glandular extracts, contact dermatitis, keratitis, corneal dystrophy, and the use of heat and cold.

It is a concise text on ocular therapeutics. Therapeutical measures are presented in a clear manner, and indications are cited.

Should serve as a useful guide for quick reference because it is dependable.

Medical Morals and Manners. By Hubert A. Royster, M. D. Pp. 333. Price, \$2.50. University of North Carolina Press.

Doctor Royster has compiled an interesting series of chapter comments upon practice, professional conduct, public relations, and personal observations and experiences. They are based on his writings and public contacts during forty years of surgical practice.

Doctor Royster does not sermonize. His statements and advice are sound. He has observed them in the years of distinguished service to his state and nation as well as in private practice. He dignified his profession.

To young physicians, yes, and to older men, this volume is recommended. It will profit them to read and ponder upon the sage advice given. Every hospital and college library should have this volume on its library shelves.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 216)

Obituary.—Henry Gibbons, Jr., M. D., was born in Wilmington, Delaware, September 24, 1840. His father was Henry Gibbons, M. D., later on one of the best known and appreciated physicians in California; he was an excellent practitioner, teacher, and lecturer. For many generations Dr. Henry Gibbons' ancestors were Quakers. He came to California in 1850. Dr. William Gibbons of Alameda and Dr. Edward Gibbons of Oakland, California, both now dead, were his brothers. . . .

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Dr. Henry Gibbons, Jr., came to California via the Isthmus with his mother and four sisters in 1851. They lived in San Francisco, California, until 1863. He attended the high school in San Francisco and was graduated from there in 1859. He then commenced the study of medicine at the earnest request of his father, but was strongly inclined to higher mechanics, having natural gifts in that direction. . . .

He was a highly moral man in every particular. In more recent years he was a trustee of First Unitarian Church.

He married Marie Raymond in 1871. She died in 1899. Their children are Dr. Morton R. Gibbons, Dr. Henry W. Gibbons, Miss Ida L. Gibbons, Miss Miriam Gibbons, of San Francisco, California, Mrs. E. M. Shinkle (wife of Major Shinkle, U. S. A.), and Mrs. Perry Evans of Berkeley, California.

In the death of Doctor Gibbons this community has met with a severe loss. He lived in an age and under such

(Continued on Next Page)

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AGENTS

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

circumstances that he was peculiarly valuable to many, for whom he was glad to do. Thousands in San Francisco are indebted to him for life, health and resultant happiness. His special practice placed him in a confidential position that was never betrayed. The poor, or a friend, never called on him in vain, and the young physician had his eye, hand, ear, and heart at command. . . .

From an Article on "Variations in the Tonicity of the Abdominal Musculature and Their Significance" by J. L. Lohse, M. D., Oakland.—The selection of this subject for a paper was determined upon by the conviction that a great and unwarranted lack of consideration has been given to one of the most important systems of our body, namely, the muscular system; and that by this neglect much is overlooked that has a direct bearing upon the prevention of disorders as well as upon their correction when once they are an established condition. Our failure to appreciate its importance has left open a large field which is responsible for the founding of many large schools for the teaching of irregular practitioners. . . .

From an Article on "The Management of Cases of Pulmonary Tuberculosis, with Remarks on Treatment" by R. A. Peers, M. D., Colfax.—Mr. President, Members of the California Academy of Medicine, and Visitors: It is with no small degree of trepidation that I address you on the subject of tuberculosis. I feel that with the immense amount of interest in this subject which has been stimulated by the studies and writings of others and the vast amount of literature bearing upon the treatment of tuberculous patients, it will be extremely difficult for me to bring before you anything that has not already been said or that can possibly be considered new. I have thought, however,

that it would possibly be of interest to you to give in some detail a description of the methods which have afforded me a certain degree of success in the management of these cases. I use the word "management" in preference to "treatment" because at present we have no treatment for tuberculosis. True we have drugs that are of value in the control of certain symptoms and a so-called specific therapy which in some selected cases influences favorably the course of the disease, but nothing that can be called a treatment. The road to success lies in the proper management of the patient's daily life—a regulation of his hours of rest, exercise, diet, and entire environment. . . .

From an Article on "Medical Laws of California" by Clarence F. Lea, Santa Rosa.—California, in common with most of the other states of this country, has attempted to regulate the practice of medicine. In 1876 the legislature passed an act specifying the requirements for the right to practice medicine and providing for a State Medical Society, who had charge of issuing certificates to persons who established their right to certificates to practice; said Medical Society was also given power to refuse the right to practice to individuals guilty of unprofessional conduct, and for similar cause they could revoke certificates to those who were practicing. In that original act a person practicing medicine was defined to be one "who shall profess publicly to be a physician and to prescribe for the sick, or who shall append to his name the letters of M. D." . . .

From an Article on "Treatment of Vascular Naevi with Carbon Dioxid Snow" by G. H. Mize, M. D., San Francisco.—It is not my desire this evening to furnish an exhaustive treatise on carbon dioxid snow and the microscopical changes resulting in the tissues from its use, but to present to you the salient points in the preparation and the clinical utilization thereof. . . .

(Continued on Page 20)

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

From an Article on "A Case of Partial Tremulous Scrivener's Palsy: The Psychogenesis of Which Was Discovered in One Interview Which Led to Recovery Through the Patient's Own Effort" by Tom A. Williams, M. B., C. M.—A naval paymaster, aged thirty-two years, single, was referred to me early in 1908 by his brother, a physician in Boston, because when he returned to work after the drainage of a large perityphlitic abscess which discharged for a month, he found that his signature was no longer uniform. Instead of improving, he became worse with practice; and although his other writing was not so seriously impaired he had ceased writing entirely and conducted his correspondence by dictation and signatures. . . .

The American Medical Association Press Service to Newspapers.—The following is a circular letter sent out by the Press Bureau of the Council on Health and Public Instruction to all the five thousand and more papers on its list. In many instances the papers published this letter in full. It will show you a little of the attitude and of the nature of the work of the Association in connection with publicity. . . .

Attacks on the Association.—For some time past, the American Medical Association has been the subject of attack. Attempts have been made to mislead the public as to what it is and what it is doing. The newspapers themselves have originated very little of the "copy" used. It has been inspired by, and, in most cases, prepared by, those who have good reason to be hostile to the American Medical Association.

An organization has recently arisen whose principal object seems to be to attack the American Medical Association under cover of opposition to its origin to those who were and are being injured by the work of the Association.

(Continued on Page 23)

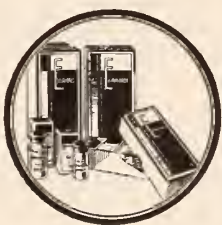
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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

The American Medical Association has no secrets. It has no desire to keep from the public what it is doing. On the contrary, it wants the public to know what it is doing. It will then be apparent why the Association has incurred the enmity of certain interests.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 216)

to practice. The three had been fined \$100 each for violating the Act. They said they were graduated from the California University of Liberal Physicians and held licenses from the city of Hawthorne to practice. The trio then sought to take the dispute into federal court by asking the injunction on the ground the California law violated the Federal Constitution. The appellate court agreed with the Federal District Court at Los Angeles that there was no federal question involved." (Oakland Tribune, February 16, 1937.)

"Governor Frank F. Merriam has just completed twenty-two appointments to various State regulatory boards. . . . The Governor reappointed Dr. C. E. Schoff of Sacramento and Dr. W. S. Geistweit, Jr., of San Diego to the Board of Medical Examiners. . . ." (Los Angeles Journal, February 16, 1937.)

"A federal court jury convicted today two Milwaukee lawyers and a New Orleans resident of mail fraud. They were accused of swindling sufferers of eye diseases in operations which the Government contended netted a nation-wide ring \$20,000,000 in twenty years. The de-

fendants were Frank Mackett, Jr., and William Haney of Milwaukee and Samuel Birnstein of New Orleans." (Associated Press dispatch dated Milwaukee, January 22, 1937, printed in the San Francisco Call-Bulletin, January 22, 1937.)

"The right of physicians to testify as to the effect of any kind of treatment for tuberculosis was affirmed by Superior Judge Carl Stutsman in a case concluded yesterday in his court, wherein a jury awarded a \$10,000 judgment against a local chiropractor for malpractice. The suit followed the death of a 6½-year-old boy, who, suffering from tuberculosis of the spine, in the neck area, received four and one-half months of chiropractic treatments. . . . Testimony of physicians appearing as expert witnesses was that the proper treatment of tuberculosis is no treatment, or immobilization, and the court sustained the right of representatives of the medical profession to testify against chiropractors to this extent." (Los Angeles Journal, January 19, 1937.)

"Repercussions of the smashing of the huge Pacific Coast illegal operations ring here a few months ago were heard again today, following the death yesterday of Mrs. Eva Cooke Louis, 21-year-old housewife. Victim of complications following an alleged illegal operation, her death, officers said, may reveal a hitherto undisclosed link in the coast-wise chain. Mrs. Louis was taken to Torrance Memorial Hospital last Sunday in a serious condition. The physician who had performed the operation upon her on January 14 disappeared when complications set in. . . ." (Los Angeles Herald-Express, January 23, 1937.)

"Gypsy Dan Chandler, Indian medicine man, was sentenced to 180 days yesterday by Municipal Judge Dawson
(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

for practicing medicine without a license. Gypsy Dan was operating a herb and snake-oil store at 113 East Fifth Street, according to John Ronan, Special Agent of the State Board of Medical Examiners." (Los Angeles Times, January 27, 1937.)

"One man was a blackmailer. Another was a highway robber. A third tried to kill a man. A dozen more were auto thieves, burglars, and professional thugs. And all were turned loose on parole. In other words, the parole boards turned society over to these desperadoes so they might continue their lawlessness. What were the results? Those same men are now being hunted frantically by G-Men for practically every crime on the calendar—including kidnaping and murder. . . . Just so many 'noble experiments' gone wrong. With the joke on the public—as usual." (Editorial from San Francisco Call-Bulletin, February 4, 1937.)

"Arguments on the petition of Dr. George W. O'Donnell of San Francisco for the renewal of his license as a practicing physician were heard before Superior Judge Malcolm C. Glenn today. Doctor O'Donnell's license recently was revoked by the State Board of Medical Examiners on the ground he performed an abortion. The physician was represented by Attorney Percy G. West of Sacramento." (Sacramento Bee, February 3, 1937.)

"The 'cure' for tippling kicked back on the 'doctor' today. Harry B. Miller, manager of the Samaritan Treatment Sanitarium, 1222 Lake Shore Drive, Oakland, was charged with having drunk so much he was forced to become a patient. John D. Owen, owner of the sanitarium, brought suit in Alameda County Superior Court to force

an accounting and obtain an injunction against Miller's management—Owen called it 'mismanagement.' Owen demanded accounting of \$1,600 in sanitarium funds and an injunction removing Miller as manager. 'Miller got so drunk he had to take the cure himself,' Owen told the court. Miller did not appear. A temporary injunction was granted until Miller can be present in court." (San Francisco Call-Bulletin, February 15, 1937.)

"Losing their long battle for reversal of their convictions on narcotic charges, Dr. Edward H. Williams of Los Angeles and Dr. Frank T. Cary of Inglewood yesterday were denied review of their cases by the United States Supreme Court. The tribunal, according to dispatches from Washington, refused to review judgments against the physicians by the Ninth Circuit Court of Appeals. Doctor Williams, former head of the Los Angeles narcotic clinic, was indicted on five counts for selling, bartering and dispensing narcotics to addicts by means of a prescription. He was convicted on one count. It was the Circuit Court's ruling that an assignment of errors by the federal trial court here was not filed within the time allowed. Doctor Williams, a noted psychiatrist, was placed on two years' probation by Federal Judge Harry Hollzer. Doctor Cary was convicted on five counts and was sentenced to serve twelve months in a federal road camp on three counts of the indictment, to run concurrently, and was placed on five years' probation on the remaining counts. Both physicians denied unlawful issuance of prescriptions." (Los Angeles Examiner, February 9, 1937.)

"Efforts by attorneys for four physicians convicted in the recent sensational Pacific Coast operations ring trial to obtain continuances before the State Board of Medical Examiners of trials for their clients on revocation of licenses were denied today as the Board resumed sessions

(Continued on Page 27)

Old Way...

CURING RICKETS in the CLEFT of an ASH TREE

FOR many centuries,—and apparently down to the present time, even in this country—ricketic children have been passed through a cleft ash tree to cure them of their rickets, and thenceforth a sympathetic relationship was supposed to exist between them and the tree.

Frazer* states that the ordinary mode of effecting the cure is to split a young ash sapling longitudinally for a few feet and pass the child, naked, either three times or three times three through the fissure at sunrise. In the West of England, it is said the passage must be "against the sun." As soon as the ceremony is performed, the tree is bound tightly up and the fissure plastered over with mud or clay. The belief is that just as the cleft in the tree will be healed, so the child's body will be healed, but that if the rift in the tree remains open, the deformity in the child will remain, too, and if the tree were to die, the death of the child would surely follow.

*Frazer, J. G.: *The Golden Bough*, vol. 1, New York, Macmillan & Co., 1928



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 24)

in Foresters' Hall, 1329 South Hope Street. Continuances were asked on grounds that the three physicians have appealed their convictions in Superior court and that the Medical Board should not act to revoke their licenses until all court action is completed. The physicians in question are: Dr. James H. Beggs, Oakland; Dr. Jesse C. Ross, San Francisco; Dr. Alfred Henry Valentine St. John and George E. Watts, both of Los Angeles. . . . (Los Angeles *Herald-Express*, February 9, 1937.)

"The conviction of Dr. Thomas P. Ratigan, Jr., prominent Seattle physician, who, according to federal officials, made more than \$100,000 in one year by illegal sale of narcotics, was affirmed by the United States District Court of Appeals here yesterday. In its ruling the court approved the sentence meted out to the doctor in Seattle of seven years in a federal penitentiary and a fine of \$10,000. Doctor Ratigan was arrested and convicted in the northern city, and his attorneys appealed the conviction." (San Francisco *Examiner*, February 24, 1937.)

Mrs. Hilma Thompson, fifty-seven, was found critically injured last night, lying in a pool of blood in front of her apartment at 2361 Union Street. Patrolmen at Central Emergency Hospital said Mrs. Thompson named her husband, John Thompson, a chiropractor, as responsible, but later retracted the charge. . . . Officers who took Thompson into custody declared he had been drinking and announced that he would be held on charges of assault with intent to do great bodily harm, and intoxication. Thompson asserted his wife had "fallen out of bed." (San Francisco *Examiner*, February 21, 1937.)

(Continued on Next Page)

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★ *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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149-154. *Proc. Soc. Exp. Biol. and Med.*,
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(Continued from Preceding Page)

"Two members of the asserted coast-wide illegal operations syndicate uncovered last summer were freed on bail from the county jail in an unexpected action yesterday by the Appellate Court. Over protests of the Attorney-General's office, Valentine St. John and James Beggs were allowed to obtain their freedom on \$3,000 bail each, pending outcome of their appeals. Deputy Attorney-General Bayard Rhone protested the action. 'Bail never has been granted on such conditions before,' Rhone said. Convicted on five counts of conspiracy and performing illegal operations, the pair were serving sentences of ten to twenty-five years. Last week they were deprived of their licenses to practice by the State Board of Medical Examiners." (*Los Angeles Times*, February 16, 1937.)

The Effect of Benzedrine Sulfate on Intelligence Scores.—Sargant and Blackburn (*Lancet*, London, 2: 1385, Dec. 12, 1936), conducted an investigation to determine whether the increased confidence and mental alertness reported after the use of "Benzedrine Sulfate" (benzyl methyl carbinamine sulfate) would be accompanied by any real improvement in general mental efficiency as shown by psychometric tests.

After administration of 20 milligrams of "Benzedrine Sulfate," Cattell's "intelligence tests" were given. The results showed the increase in score of over 8 per cent as compared with previous tests without "Benzedrine." The score of a control group receiving placebos remained unchanged.

Individual examinations showed that "Benzedrine" has more effect on mildly depressed cases than on schizophrenics where personality changes are more profound. Even better results might have been obtained if the dosage had been graded to each patient's requirements.

The authors suggest that the drug may prove useful in certain cases where mental efficiency is temporarily impaired by emotion, anxiety, or mild depression.

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American Medical Association Essentials for An Approved Clinical Pathologist

An approved clinical pathologist should be a licensed graduate of medicine. He shall have specialized in clinical pathology, bacteriology, pathology, chemistry, and other allied subjects for at least three years, and he should be reasonably familiar with the manifestations of disease in the body. The director of a clinical laboratory shall be on full time or have definite hours of attendance, devoting the major part of his time to this specialty. A clinical laboratory is an institution organized for the practical application of the fundamental sciences by the use of specialized apparatus, equipment and methods, for the purpose of ascertaining the presence, nature, source, and progress of disease in the human body.

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Tongue Cancer.—According to M. J. Holmes, M.D., the facts about carcinoma of the tongue are:

1. Glandular metastases are the cause of death in the overwhelming proportion of cases at the present time.

2. There is no evidence that radiation therapy can prevent or cure these glandular metastases.

3. There is abundant evidence that surgical excision, properly performed, can in a definite proportion of cases (a) prevent the occurrence of glandular metastases, (b) cure glandular metastases according to their extent and fixity.

4. A surgical excision can cure primary lesions in the tongue when the principles of cancer surgery can be followed; but if the anatomical situation is such that these principles cannot be carried out, and to avoid mutilation even if they can, we must rely upon the selective destructive effects of radium for a cure of the primary growth.

5. It seems that in appropriate dosage radium is capable of producing a remarkable disappearance of outward signs of carcinoma of the tongue in situations where surgical excision cannot be contemplated.—*Medical Journal of Australia*, August 15, 1936.

What Price Recreation.—And one has only to look at the hollow-eyed, body-blistered, head-cold infected men and women limping back from week-ends and vacations to realize fully what atrocities against mental and physical health are self-inflicted under the guise of recreation. The head of a large business firm told me that he dreaded the vacation season each year because of the heavy toll of illnesses that always followed for weeks afterward among his employees, to say nothing of their reduced mental efficiency and lowered morale. It is well that we think a bit seriously about this business of refreshing ourselves in this period of our history when shorter working hours give greater leisure. Do we know how to spend them to the best advantage? What price Recreation!—*Esther Loring Richards, M. D.*

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* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$——, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the —— Gift, the following described real property situate in the County of ——, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.



Scrambled train orders invite disaster. So in railroading as little as possible is left to memory. Train orders must be written!

Word-of-mouth prescriptions for vitamin products invite trouble, too. If confused or forgotten, the patient may get on the wrong track by selecting a deficient product. And because appearance, taste, smell or weight cannot help the patient to select wisely, low price may decide the choice instead of what matters—certainty of full vitamin content.

That is why many physicians make it a practice to write all their prescriptions for Haliver Oil with Viosterol, and to specify ABBOTT whenever vitamins A and D are indicated. In this way physicians can be

sure that their patients will receive all those vitamin units they prescribed for them.

Abbott's complete control throughout production makes certain that only highest quality fish oil is used. Abbott's rigid bioassays assure vitamin content true to label claims. Another very important assurance of quality is Abbott Laboratories' unique background of original research and manufacturing experience in the vitamin field.

Prescribe routinely for pregnant or lactating mothers, for children and any others who may need additional vitamins A and D. Available at prescription pharmacies everywhere in 3-minim capsules in boxes of 25, 50, 100 and 250. Also in 10-cc., 20-cc. and 50-cc. vials.

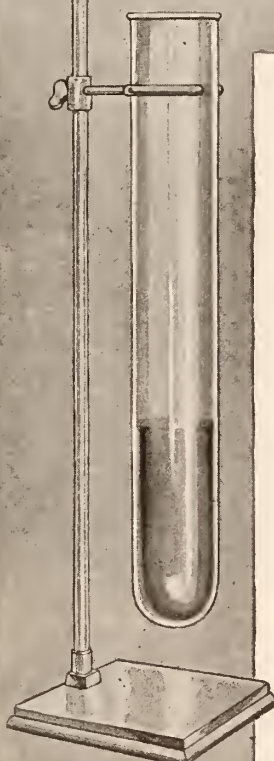


ABBOTT'S HALIVER OIL with Viosterol

Diabetic Acidosis

DANGER!

EMERGENCY!

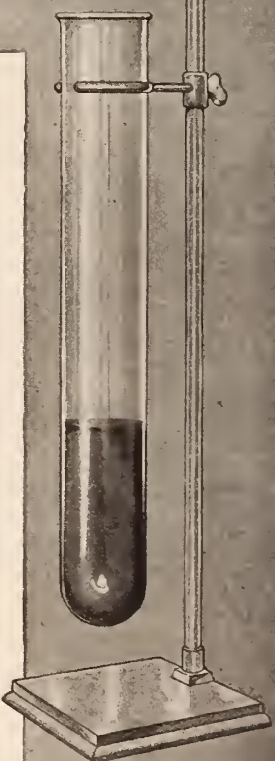


ORANGE-YELLOW
Positive Test for Glycosuria

"No greater crisis exists in medical practice than the occurrence of diabetic coma. The comatose patient is usually on the road to recovery or is dead within 24 hours. His future is delicately balanced in the mind and hands of his physician."

—Sharkey

(Ohio State M. J. 32:123, 1936)



WINE RED
Positive Diacetic Acid Test

*Benedict qualitative test
for sugar in the urine*

*Ferric chloride test for dia-
cetic acid in the urine*

Early Portents	Later	Then
Polyuria	Loss of strength	Nausea and vomiting
Polydipsia	Loss of weight	Desiccating of tissues
Polyphagia	Loss of appetite	Unconsciousness

Important Factors in Treatment

1. INSULIN early and in repeated doses. 2. FLUIDS to combat dehydration.
ILETIN (INSULIN, LILLY)

ELI LILLY AND COMPANY

Principal Offices and Laboratories, Indianapolis, Indiana, U. S. A.

CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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EDITOR GEORGE H. KRESS

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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles; Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

SOME OF THE LEGISLATION PROPOSED AT SACRAMENTO

Two Hundred and Fifty Proposed Laws Are Related to the Public Health.—An examination of the more than 4,000 proposed laws introduced at Sacramento in January, during the first part of the fifty-second legislative session, shows that about 250 have a direct bearing on public health and medical practice. For the information of members of the California Medical Association, the list compiled by the Association's Committee on Public Policy and Legislation is printed in this issue, on page 205.

Every member of the California Medical Association, therefore, owes it to himself, as citizen and as physician, to take time to glance through that index of suggested legal enactments, some of which—if they went on to passage—would work havoc to the interests of both public and the medical profession. No doctor of medicine, indeed, need feel above doing this, for if he seriously thinks that he lowers the dignity of himself or that of his profession by acknowledging a live interest in proposed laws such as might create great and detrimental changes in his own practice, and that of his colleagues, he certainly may be accused of having a distorted point of view.

* * *

A Heavy Price Is Paid for Indifference in Legislative Matters.—It is true that the successful practice of medicine—in which, from the beginning of the art, so much has always depended upon the confidential and trustful physician-patient relationship—prevents the acceptance by physicians who are in active practice of full-time civil positions and responsibilities; but this fact does not imply that medical men must stand aloof from active observance of legislation affecting medical practice or the public health. It may be said, on the contrary, that in the quiescent attitude of doctors in the past (or, shall we even say their indifference?) is to be found a partial explanation of some of the radical socialized-medicine propaganda which have been so much in evidence in the last several years.

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

Absence of Medical Men in the Legislature.—Therefore, it may be in order to call attention to the complexion of the present California Legislature, a roster of whose Senate and Assembly members is given on page 208, disclosing somewhat of these interesting facts:

The Senate, composed of forty members, contains twenty-five Republicans and fifteen Democrats. With respect to occupation, it has sixteen farmers, twelve attorneys, five real estate and insurance agents, three publishers, three merchants, and one druggist. In the reapportionment several years ago, the plan adopted gave almost every county one senator—although for some of the smaller counties it was necessary to effect a grouping. The balance of power in the Senate, therefore, is largely in the counties of lesser population, or the so-called "rural counties."

The Assembly, made up of eighty representatives, includes forty-six Democrats, thirty-three Republicans and one member elected by "write in" process; and respecting occupation, it has thirty-four attorneys, fourteen real estate and insurance agents, thirteen retail business men, seven farmers, five teachers, three labor leaders, three civil engineers, and one publisher. In the Assembly, the metropolitan areas and cities have a majority of votes.

In the above summary it will be noted that while twelve of the forty senators are attorneys, and thirty-four of the eighty assemblymen belong to the legal profession, there is not a single physician in either the upper or lower chamber! It is unfortunate that such is the fact, because the presence of several physicians on the Senate and Assembly floors could be of real value in bringing about the enactment of sane public-health legislation.

* * *

Medical Practice Codification, Medical and Hospital Service Bills.—In the January issue, special mention was made of the codification of the Medical Practice Act, a proposed law providing for the creation of medical service associations, and an act providing for the regulation and control of corporations organized for the purpose of operating nonprofit hospital service plans. These three measures continue to receive the close scrutiny and supervision of the California Medical Association Committee on Public Policy and Legislation, and component county societies will be promptly informed if complications arise.

Apropos of the Williams bill for medical and hospital services to be rendered on an insurance basis, readers are referred to comments made by Chester H. Rowell in the San Francisco *Chronicle* discussing the act sponsored by Senator Williams. These comments are reprinted in this issue, on page 212.

* * *

Law for Registration of Nurses.—At the February 20 meeting of the State Board of Health (which, under the existing law, has the responsibility of supervising schools of nursing and the registration of nurses) that body went on record as being opposed to Assembly Bill 2125, which would exempt certain schools of nursing from the

provisions of the present law, when "such school of nursing is conducted by a university or college in the State of California . . ." The members were unanimous in their opinion that the minimum standards laid down for schools of nursing should be complied with by all schools in the State, and that no exemption from the existing laws concerning schools of nursing and registration of nurses should be granted, even to universities and colleges.

* * *

Optometric Amendments.—The optometrists, in Assembly Bills 1137 to 1142, propose amendments to the Optometric Act which could seriously embarrass physicians and surgeons who are eye specialists. The opticians who grind lenses would be brought under the jurisdiction of the Optometric Board; but why, is not stated. Also, paragraph 3042 in Assembly Bill 1137 states: "The provisions of this chapter do not prevent a duly licensed . . . optometrist from *treating* or fitting human glasses to the eye . . ." Phraseology, such as this, with implied legal right to "treat" eyes, will need careful consideration.

* * *

Supervision of Persons on Entering the State. The public-health menace, in some of the indigent and other camps in California, was discussed editorially in the January number of CALIFORNIA AND WESTERN MEDICINE. So serious has this evil become, that the State Board of Health, in Assembly Bill No. 2115 (Redwine), has asked the Legislature to enact a law that would permit the Board to establish a Division of Health Inspection, with power to inspect all persons entering this State, to determine their condition of health. At the present time, the State is powerless to combat the entrance of persons who are both indigent and diseased.*

* * *

Component County Societies to Work Through the California Medical Association Committee on Public Policy and Legislation.—To comment on all the 250 proposed laws relating to medical practice and the public health would require one or two entire numbers of CALIFORNIA AND WESTERN MEDICINE. It is hoped, therefore, that the brief survey and lists of measures, with their reference numbers as Assembly or Senate bills, as given in this issue,† will demonstrate to members of the California Medical Association that the Committee on Public Policy and Legislation again has a large task on its hands. Officers of component county societies are requested to be alert and, when called upon for service, to be promptly up and doing; but, as before stated, always to act in conjunction with and through the California Medical Association Committee on Public Policy and Legislation.

Members who wish to read the text of certain bills may obtain copies by sending their request (with bill numbers) to the California State Printing Office, Sacramento.

* See also Opinion of the State's Attorney General, on page 177.

† For list of proposed laws, see page 205.

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

Remarkable Growth and Record of the California Auxiliary.—The thought has not infrequently come to us: How many of the 5,500 members of the California Medical Association appreciate the growth and good work of the Woman's Auxiliary to the Medical Association? For those who have not watched its development, a perusal of the letters of county units which make up the Auxiliary, and which appear in each issue of CALIFORNIA AND WESTERN MEDICINE, cannot do otherwise than instill an increased pride in the educational and other work which these organized groups of women—the wives and daughters of physicians—have so consistently and efficiently carried on since the founding of the Auxiliary in May, 1929—a brief eight years ago.

The national woman's auxiliary came into being in 1922, but it was not until the Sacramento meeting of the California Medical Association in 1928 that members of the California Medical Association Council were ready to authorize the movement for California. At the Council meeting of April 30, 1928, on our motion, a committee was appointed to bring in a report for submittal to the House of Delegates, and the minutes of the May 2, 1928, meeting of the House include the following item:

(d) *Woman's Auxiliary.*—The Reference Committee approves the recommendation of the Council that a Woman's Auxiliary be formulated in California as it exists in the majority of states.

At the Council meeting of June 1, 1928, the subject was again discussed, the minutes stating:

On motion of Doctor Gibbons, duly seconded, it was

Resolved, That a committee be appointed to present a plan for the formation of the Woman's Auxiliary in California for consideration at the next meeting of the Executive Committee. . . .

Chairman Hamlin appointed George H. Kress (chairman), Edward M. Pallette, and Hartley F. Peart as members of the committee.

Again, in the minutes of the California Medical Association Executive Committee meeting of August 11, 1928, it is recorded:

Woman's Auxiliary.—George H. Kress, chairman of the committee on plans for the organization of the Woman's Auxiliary in California, presented proposed rules for the information of the committee. It was decided that the wives and adult sisters and daughters alone should constitute the active members.

Later, a letter of transmittal was sent to the component county medical societies, with copies of the by-laws or rules to be used in the organization of county auxiliaries, and also a letter outlining a simple procedure for initial organization. It was in this manner that the first county auxiliaries came into being, the State Auxiliary being formed in the spring of 1929.

* * *

California Woman's Auxiliary of 1937.—Today, as noted in the front section directory of each issue of CALIFORNIA AND WESTERN MEDICINE, local auxiliaries exist in the counties of Alameda, Contra Costa, Fresno, Kern, Lassen-Plumas-Modoc, Los Angeles, Marin, Orange, Riverside,

Sacramento, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Clara, and Siskiyou.

For proof that these are not "paper societies," but units of alert women, anxious to aid in the promotion of the public health, and of scientific and organized medicine, one need only occasionally read their reports, as printed each month in the OFFICIAL JOURNAL.

As time goes on, we are more and more impressed with the real value of the county auxiliaries, and also that component county medical societies, which have not taken steps to organize such units, may well ask themselves why they do not do so? Officers of county medical societies need do nothing more than write to the State Auxiliary officers to secure sympathetic and efficient coöperation. A Woman's Auxiliary to every County Medical Society would mean stronger component county units, and a greater and more efficient State Association.

* * *

Two Excerpts from the Los Angeles Auxiliary Year Book: Worth Reading.—Before leaving this subject we would present two excerpts from the impressive 1935-1936 year book of the Woman's Auxiliary to the Los Angeles County Medical Association, a volume of forty-four pages, the first quotation touching on the objects of the Auxiliary:

CLUB POLICIES

1. Our aim is to assist in the advancement of the prevention of disease. Health education.
2. To secure better legislation indicated in the pursuance of these ends.
3. To extend the aid of the medical profession to all organizations that look to the advancement of public health conditions.
4. To promote acquaintanceship among physicians' families, and bring about unity and friendliness.
5. Philanthropic—give community service whenever such service is needed, particularly service related to the medical profession.
6. To assist in entertainments at all medical conventions.

Are not the above most laudable aims? Let it be remembered, in connection therewith, that many of the present-day problems having a relationship to economic and allied phases of so-called socialized medicine have come into being because, in the past, physicians failed to sense the importance of maintaining proper educational contacts with lay organizations; where, only too often, biased and visionary propagandists, through addresses teeming with inaccuracies and wild theories, have led substantial citizens, both men and women, astray, by the use of high-sounding phrases, containing only minor substance of little worth.

We close these comments with a second excerpt, showing the fine spirit our wives and daughters hold for their own fellows in auxiliary service, to be found on the dedication page of the 1936-1937 Los Angeles Year Book, inscribed to the retiring president, Mrs. John Vincent Barrow:

TO DOLORES M. BARROW

For her long and loyal service in the Auxiliary,
For her early understanding and enthusiasm during its formative years, both as county director and as State councilor,

For her fine record through two administrations as a State vice-president in broadening the Auxiliary's scope of interest and increasing its field of services,

For her leadership during two and a half years as county president, when she built the membership to the largest county group in the country,

For the joy she finds in her work,

For the inspiration she carries to others,

For her fearless pioneering spirit,

For the trueness of her friendship,

We, the members of the Los Angeles County Medical Auxiliary, dedicate this, the 1936 edition of our year-book.

After consideration of what the California State and County Auxiliaries have accomplished in eight brief years, must we not agree that all members of the California Medical Association may well be proud of the Auxiliaries, and the loyal women who make up the membership and carry on the work of these accessory units so efficient to scientific and organized medicine?

ARMY MEDICAL LIBRARY

The Army Medical Library of Washington, D. C.—Far out as we are, on the Pacific Coast, we may be pardoned if, at times, we seem to forget the immense service rendered by some of the medical institutions and activities headquartered along the Atlantic seaboard. Not the least among these is the Army Medical Library, located at Seventh Street and Independence Avenue, S. W., Washington, D. C., which will become, it is hoped, in the not far distant future, an adjunct of the Army's Walter Reed Hospital of that city.

* * *

Tribute to Army Medical Library by the Late William H. Welch.—It was of this library that the late William H. Welch of Johns Hopkins said:

I have been asked on more than one occasion what have been the really great contributions of this country to medical knowledge. I have given the subject some thought, and think that four should be named:

1. The discovery of anesthesia.
2. The discovery of insect transmission of disease.
3. The development of the modern public health laboratory, in all that the term implies.
4. The Army Medical Library and its Index-Catalogue; and this library and its catalogue are *the most important* of the four.

The Army Medical Library's bigness is shown in its possession of more than one million volumes or items, and of some 450 of the 600 volumes printed prior to or shortly after the year 1500. The oldest of these medical incunabula in the Army Medical Library is Johannes Gerson's *De pollutione nocturna*, from a Cologne press under date of 1467.

* * *

The Late Colonel John Shaw Billings.—In 1936 the Army Medical Library—known up to some fifteen years ago as the Library of the Surgeon-General's office—was one hundred years old. In its growth, it owed its greatest development to the late Colonel John Shaw Billings, a graduate of the Medical Schools of the Uni-

versity of Cincinnati (Miami-Medical College of Ohio), who, as early as 1876, outlined the type and scope of the *Index-Catalogue*, destined to appear, between 1880 and 1895, in sixteen large quarto volumes. In 1879, a monthly catalogue, the *Index Medicus*, was brought off the press by Billings, but the publication, maintained for a while by private subscription, was not able to survive; and in 1899 efforts were made to have the Carnegie Foundation take over its production. This was accomplished, for the period 1903-1927, when again a new sponsor was found in the American Medical Association, which merged it with its own *Quarterly Cumulative Index*, established in 1916, making it the *Quarterly Cumulative Index Medicus*.

* * *

The Largest Medical Library in the World. The Army Medical Library of the United States has the largest collection of medical books in the world, and the service it has rendered to American and World Medicine is hard to estimate. Its worth is splendidly attested in a tribute from the late William Osler, who, as long ago as 1912, wrote: "Probably few men in the profession owe a deeper debt of gratitude to the Surgeon-General's Library than I." As part of the Library's activities, it maintains the Army Medical Museum, also the largest of its kind anywhere.

It is well for California physicians to keep the Army Medical Library in mind, because it extends its facilities to the medical libraries of the State, and, through them, to the physicians of California.

* * *

Army Medical Library Worthy of Congressional Appropriations.—The record of great achievement by the Army Medical Library makes it proper for component county societies to inform the United States Senators and Congressmen from California* that the physicians of the Golden State are in full sympathy with the proposed annual federal appropriations, to provide adequately not only for additions to the volumes already in the Library and give full support to the *Index-Catalogue*, but also to make ample provision for adequate housing in the proposed building to be erected on the new site adjacent to the Walter Reed Hospital in Washington.

THE QUESTION—CAN A CORPORATION PRACTICE MEDICINE IN CALIFORNIA?: THE STATE'S ANSWER TO THE CORPORATION'S APPEAL TO THE CALIFORNIA SUPREME COURT

An Interesting and Important Brief.—On February 4, 1937, the Hon. U. S. Webb, Attorney-General of the State of California, and Lionel Browne, Deputy Attorney-General, as legal representatives for the Respondent (The People of the State of California, *ex rel.*, State Board of Medical Examiners), filed their brief in the appeal

*For list of United States Congressmen from California, see page 208.

taken by the Pacific Health Corporation from the judgment of the Superior Court of the State of California, in and for the County of San Francisco—Hon. C. J. Goodell, Judge,* presenting, as their viewpoint of the issue before the Supreme Court, the following:

THE ISSUE

Was the court correct in determining that the appellant corporation [Pacific Health Corporation] was engaged in the practice of medicine where it paid commissions to solicitors who secured applications for contracts, which, if accepted by appellant [Pacific Health Corporation], permitted the contract holder to secure medical or surgical services from licensed physicians chosen and compensated by appellant corporation [Pacific Health Corporation], or can a corporation undertake to supply medical services through licensed persons chosen and compensated by it, or is it, in so doing, wrongfully engaged in the practice of medicine?

* * *

Points in the Arguments of the Attorneys-General.—In the foreword of the brief, the Attorneys-General state:

FOREWORD

Appellant [Pacific Health Corporation] agrees a corporation cannot legally practice medicine or any other profession, but contends it is not practicing medicine where it undertakes, for a consideration paid by its contract holders, to supply and pay for the services of licensed physicians and surgeons of its choice.

The question before this court, appellant [Pacific Health Corporation] argues, is a social one, and an affirmation of the judgment at bar will outlaw fraternal, religious, hospital, labor union, insurance and other organizations. We [State of California] urge that an affirmation of the judgment herein will do no more than cause appellant [Pacific Health Corporation] to stop doing those things which constitute the practice of medicine, and insist the matters referred to were not before the court below. We believe it advisable to consider those matters which were the subject matter of the agreed statements of fact.

Matters not involved in such statements can be considered if, as, when, and where they arise.

Lack of space prevents giving details of the argument, as outlined in the seventy-six pages needed to impart their understanding of the law of the case, which was analyzed and presented under the following headings:

- I. A Corporation Cannot Practice Medicine
- II. Appellant's False Premise
- III. Rules of Construction Applicable to This Case
- IV. The Statute Defining and Regulating the Practice of Medicine Specifically Prohibits Unlicensed Persons From Engaging in the Acts Which Constitute the Practice of Medicine
- V. The Medical Practice Act Does Not Recognize That a Corporation May Hold Itself Out to the General Public as Supplying Medical Services
- VI. The Medical Practice Act Specifically Prohibits Corporations From Engaging in, Advertising and Holding Itself Out as Being Engaged in the Practice of Medicine
- VII. Appellant was Engaged in the Practice of Medicine Under the Stipulated Facts
- VIII. This Court [California Supreme Court] has Expressly Determined that It Is Illegal for a Corporation to Engage in the Practice of Medi-

cine by Employing Licensed Persons to Treat Persons Having Contracts for Medical Services With the Corporation

- IX. Authorities From Other Jurisdictions Which Permit the Corporate Practice of Medicine Do Not Represent the Law of This State
- X. The Medical Profession's View of the Question at Bar Is Immaterial
- XI. The Medical Practice Act Is Not Violative of the Fourteenth Amendment and Unconstitutional
- XII. The Affirmance of This Judgment Will Not Outlaw Fraternal, Religious, Benevolent and Other Organizations Furnishing Sick Benefits to Their Members

* * *

The Conclusions Presented by the Attorneys-General.—The above notations should be of interest because they indicate the scope and intricacies of such a legal question. Because of its importance to private medical practice, readers may find the following conclusion of the Attorneys-General, as presented in their brief, of real interest:

CONCLUSION

In that portion of its brief denominated "The Law of the Case," the respondent has answered appellant's endeavor to distinguish those cases necessarily dealing with the corporate practice of a profession. The point that a corporation cannot furnish medical services is not here involved. Indeed, under certain circumstances it is the absolute duty of a corporation to provide medical services. Under the Workmen's Compensation Act of this State, a person or corporation employer is required to supply medical attention for their employees, but this is far different than to permit corporations to make money by commercially engaging in the practice of medicine. The people of this State have never urged that a corporation cannot employ attorneys to represent it. It has the same right to employ attorneys to represent it, if it is not doing a law business, as has a natural person.

In the case entitled *In re Benseal et al.*, 124 N. Y. S. 726, it is held that a corporation cannot do indirectly that which it cannot do directly. This case cites *Bronald vs. Engler*, 121 App. Div. 123; 105 N. Y. S. 508, affirmed in 194 N. Y. 323; 87 N. E. 427, 21 L. R. A. (N. S.) 176, which holds:

"Where parties hold themselves out as pursuing the trade of a master plumber, it is a violation of Section 45 of the General Cities Law, Laws of 1900, C. 327, to carry on that business without a license. Persons so doing are not exempt from the condemnation of the statute by the employment of a licensed master plumber as a manager of the business."

It would, therefore, seem that while a corporation may employ a licensed person to render professional services for it—as, for example, to check up on the health of its employees or render first-aid service or the like—it cannot collect money from third persons for rendering services which a licensed person must, under the law, perform.

Wherefore, it is respectfully submitted that the judgment should be affirmed.

Dated: San Francisco, California, February 4, 1937.

U. S. WEBB,

Attorney-General of the State of California.

LIONEL BROWNE,

Deputy Attorney-General of the State of California.

Attorneys for Respondent.

* References in CALIFORNIA AND WESTERN MEDICINE to Judge C. J. Goodell's opinion appeared in the issues of November, 1935 (on page 324) and December, 1935 (on page 397), the full opinion being printed in the December, 1935, number (on page 460). References to other articles on the subject of corporate practice of medicine, and of California Medical Association Council action thereon, were given on page 324 of the November, 1935, issue.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 187.

EDITORIAL COMMENT†

SCHOOL HEALTH PROGRAMS AND THE MEDICAL PROFESSION*

For the most part, practitioners of medicine and surgery and their specialties have failed to recognize the significance and importance of health programs as being developed in the public schools of this country. School health programs, to a great extent, are associated in the physician's mind with a wish-wash, half-hearted attempt upon the part of school teachers to teach a few health rules such as cleanliness, posture, brushing teeth, etc.

Following are some reasons for this concept:

School health work began many years ago, with few exceptions, as a part of physical education with poorly developed programs. Some less progressive schools continued to have relatively poor programs. Few physicians contact the work directly, because it is carried on within the school department by one or more selected individuals. Physicians, by and large, are incredibly "too busy" to give thought to school health work. An occasional physician feels the school health program is attempting to replace him in his profession in the community. Many physicians are so completely absorbed in their profession, and admirably so, that they are disinclined to find time to contribute to public affairs. School health programs have not been brought to the attention of physicians properly or effectively.

Following is a brief résumé of the functions of a typical school health program:

1. Sanitation. The sanitation of our school children's physical environment, including buildings, grounds, and equipment, is important. Proper sanitary conditions in the schools not only protect the health of the pupils during their school life, but carry over educationally into adult life.

2. Health Service. First aid, health inspections by physicians and nurses, health notices, nurse follow-ups, getting the pupil into the hands of the family physician, communicable disease control, attendance problems, readmission after illness, immunization, skin testing for tuberculosis, nutrition programs, competitive athletic examinations, etc., form the bulk of health service in the schools. Communities differ individually as to methods used in promoting school health service.

3. Health Education. Health education is the most important part of the school health program. It is the fundamental responsibility of the school. It is the very basis of progress in the utilization of the discoveries of medical science to aid mankind. The family physician has difficulty in gaining cooperation with an unintelligent patient. The Public Health Department's efforts to control social and communicable diseases, to promote sani-

tation and preserve community health, are frequently made ineffective by widespread ignorance of the fundamentals of health.

Health education for the masses is developing rapidly through the public schools. Through contacts in the schools of the activities listed under the heading "Health Service," all children, rich and poor, are taught fundamentals of health. Some schools have health teachers specially trained in the field of health information. Many authentic health texts are available for reference work in the schools. The more progressive schools have appropriate health informational materials integrated with all courses of study of the curriculum. Health education is also being taught through special projects and activities of many kinds familiar only to the educator.

The school health program, as a whole, is coming to be an important influence in many communities. It is developing rapidly. It needs guidance and support. It is challenging the attention of the American physician.

How are physicians going to react to this great social and professional influence? The physician pays taxes that support the schools, his own children attend the schools, his work in the field of medicine is affected in some way by it. Is he going to be "too busy" to be interested? Is it not the type of health information taught in the public schools of any importance to him? Will he continue to be "too busy" to help guide and control, or at least be cognizant of one of the greatest influences on his profession in America?

School authorities will welcome suggestions and advice of physicians of good standing in the community. What group could a school department turn to for advice and consideration of its health problems that is better prepared than the physicians themselves? One of the greatest responsibilities of the medical society and the Public Health Department of every community is to give support and guidance to the school administration in the carrying out of a well-organized and adapted school health program.

G. G. WETHERILL,
San Diego.

ADRENALIN CHLORID IN 1:100 STRENGTH IN OPHTHALMOLOGY

John Green,¹ in 1930, first reported upon the use, in fifteen cases, of a solution of adrenalin chlorid, 1:100, in the form of drops in the conjunctival sac. This concentrated solution, which had been supplied him for experimental purposes, was not again used in ophthalmology to the best of our knowledge since that time, and we have found no further mention of it in the literature until June, 1935, when Graeser and Rowe² reported at the meeting of the Association for the Study of Allergy, at Atlantic City, on a new

¹ Green, John: Two Per Cent Epinephrin Solutions as Substitutes for Laevo-Glaucosan. *Arch. Ophth.*, 5:350 (March), 1931.

² Graeser, James B., and Rowe, Albert H.: The Inhalation of Epinephrin for the Relief of Asthmatic Symptoms. *J. Allergy*, 6:415 (July), 1935.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

* From the office of the Director Health Education, San Diego City Schools.

method of administering adrenalin chlorid for prompt relief of certain allergic conditions. They found that a 1:100 solution was frequently effective in the relief of bronchial paroxysm. In August, 1935, adrenalin chlorid solution 1:100 was first supplied to the medical profession to be used in the mouth only, for inhalation by means of a glass nebulizer.

It occurred to us that this same adrenalin chlorid preparation could be used as drops in the conjunctival sac; and since December, 1935, we have thus employed it in over one hundred cases with most satisfactory results.

We have found it to be a very effective therapeutic agent in iritis and in glaucoma secondary to uveitis. In has been our impression that exudation was markedly relieved by constriction of the vessels of the iris, and that as a result of this the formation of pupillary membranes, posterior adhesions and blocking of the filtration angle by exudate, with consequent secondary glaucoma, were prevented and relieved.

In our experience adrenalin 1:100 substitutes well for, and from many points of view is preferable to, the present and past methods of applying suprenin products in ophthalmology, such as by subconjunctival injections³ or the placing of wicks⁴ of cotton saturated with a solution of adrenalin chlorid 1:1000, or by the use of concentrated solutions of synthetic epinephrin products, glaucosan⁵ and suprenin bitartrate.⁶ Its further uses and advantages will be reported at a later date in the ophthalmologic journals.

490 Post Street.

OTTO BARKAN
S. MAISLER
San Francisco.

³ Erdmann: Subconjunctival Injections of Suprenin Preparations, *Klin Monatsbl. f. Augenh.*, 52:520, 1913.

⁴ Gradle, H. S.: The Use of Epinephrin in Ocular Hypertension, *J. A. M. A.*, 84:675 (Feb. 28), 1925.

⁵ Hamburger, C.: Ersatzpräparate für Adrenalin und ihre Bedeutung für die Glaukombehandlung, *Med. Klin.*, Vol. 21, Part 2, pp. 1495-1498, 1925.

⁶ Funk, C., Dubin, H. E., and Freedman, L.: *J. Am. Pharm. A.*, 12:952, 1923.

Syphilis Is Preventable.—Syphilis is a disease of civilization and flourishes particularly in communities where there is a massing of individuals. Under such conditions, the opportunities for its spread are very much greater. It depends more upon faulty social conditions than almost any other communicable disease. While prostitution is a tremendous factor in spreading the infection, a very large number of cases are contracted outside of prostitution. It causes more mental and physical suffering than any other known disease. It is preventable and at the present time may be considered as curable. Yet it is doubtful that any other disease can compare with it in the intensity and severity of its onslaughts. Its control is greatly hampered by the attitude of the general public which too often attaches a social stigma to it. Syphilis should be regarded the same as any other infectious disease. The mere fact that it is often venereal in its origin should not hamper its control. Gradually, however, the old idea that it is punishment for sin has become dispelled. Fortunately, a new trend of public opinion can be observed. This has to do with enlightenment, the spreading of knowledge relative to the cause, effects, prevention, and treatment, all of which must be closely bound together in any program for the control of the disease.

ORIGINAL ARTICLES

CLINICAL PATHOLOGICAL CONFERENCE*

PROCEEDINGS: CORONADO ANNUAL SESSION

Foreword by President Robert A. Peers.—This morning you will notice, from the announcements which have been handed you, that we are departing from the ordinary type of program, and I think it is going to prove excellent. We have with us as an invited guest a man whom many of you know personally, and most of you know by reputation. He is Professor of Medicine at McGill University in Montreal, formerly assistant resident physician at Hopkins under the late Sir William Osler, and also later a Professor of Medicine at the University of Iowa. I feel particularly happy in introducing this speaker because, as perhaps many of you know, I am an ex-Canadian myself. It is a great pleasure to present to you this man from my former homeland, a member of a great race, a representative of a great friendly neighboring country, and a colleague from a great medical school. Ladies and gentlemen, Dr. Campbell P. Howard, Professor of Medicine at McGill University, Montreal, who will take charge of the Clinical-Pathological Conference on this morning's program. Doctor Howard.

REMARKS BY DR. CAMPBELL P. HOWARD

DOCTOR HOWARD: Doctor Peers, I hardly need to say how much I appreciate your kind reference to our sympathy in our homeland. When your Program Committee decided on this adventure, and thought of the Clinical-Pathological Conference, they had to look around for the best-natured clinician available, and someone on the committee knew that I was speaking on the day before and said, "Probably that old fellow, Howard, won't mind holding it." You have to be good-natured to hold a clinical-pathological conference, because what little pride has been left you by previous mistakes is lost at the first autopsy, as you will see presently. I have grown so accustomed to it that I no longer mind and really get as much "kick" as a pathologist does at being wrong. The only thing that I still feel it is my duty to do is to do my best, and after taking or reading a carefully prepared history, both family and personal, and of present illness, having made a complete physical examination, applied all the simple laboratory tests, and called upon my assistants in some of the more elaborate ones, I feel that I am entitled to say that I have done the best that I can. Adding up, then, the results, I feel permitted, as a rule, to come to some pretty definite conclusions. I was taught that it is my duty, or your duty, having done all those things, not to have the point of view that the case should be explored by a friendly or unfriendly surgeon, or a diagnosis made by a friendly or unfriendly pathologist. I do not think

* The Clinical Pathological Conference was held on Tuesday morning, May 26, 1936, at the sixty-fifth annual session of the California Medical Association, May 25 to 28, 1936.

Led by the late Campbell P. Howard, M.D., whose death occurred in Santa Monica, California, on June 3, 1936. (CALIFORNIA AND WESTERN MEDICINE, July, 1936, pages 4 and 102.)

that we are doing our part if we do not make the very best attempt at making a clinical diagnosis, and we insist that our students, interns, and staff write down a diagnosis as soon as the case has been partially studied. First-sight impressions, final clinical diagnosis—and then along comes the pathologist, and very often we disagree. This committee that was appointed to assist me, comprising eight men, pathologically inclined, have asked me to deal kindly with them. I am going to ask them to deal kindly with me. They have chosen very good cases and submitted six for our selection. I picked four of those six. They have drawn up in these little folders an outline, which I am going to read to you, of the case, and, at the end, the autopsy findings. I would ask you not to read the autopsy findings. Had we had time yesterday we would have obliterated from this public list the autopsy findings, so let us play cricket and not look at them. They will be a surprise to us and we will enjoy them much more if we have the surprise later.

CASE I

This first patient (history will be presented pathologically by Doctor Hall), was a white laborer, fifty-five years of age, who entered a hospital on July 25, 1935, complaining of attacks characterized by sudden loss of consciousness; pain in precordial region; shortness of breath on mild exertion; swelling of the feet and ankles. Well, one does not need to be a Sherlock Holmes with those presenting symptoms to have an impression, and I think we are justified in saying right here that that sounds undoubtedly like a cardiovascular syndrome, and our attack in the history taking should be to lay special stress on the family and personal history of cardiovascular disease. I think we are perfectly wise in admitting that.

The family history is uneventful. His own personal history, not taking that in quite the order submitted, is important, because he has been a heavy worker all his life, a day-laborer, earning his bread by the sweat of his brow. He has used alcohol and tobacco very moderately. I do not believe that is of either negative or positive importance. Being a user of both in moderation, I do not think they play very much of a rôle in the etiology of most diseases. More important than that, certainly, is a story of one severe previous illness which was diagnosed as blood poisoning; we will call it septicemia of some sort. It followed an injury to his leg. It may have been septical pyemia. That occurred in 1917, and may have left its mark on the cardiovascular tree, as we know, myocardial, possibly endocardial, and certainly arterial. The pneumonia for two months in 1922 is hardly a significant note. There is no history of a primary sore. The gonorrhea of 1925 is too distant to be significant.

Nine months before entry to the hospital, he noticed moderate loss of strength and endurance, a mild degree of nausea, and lack of his usual feeling of good health. He was given treatment and his condition improved, and he returned to work as a laborer. Three months ago he noticed

shortness of breath on exertion, swelling of the feet and ankles, and felt unable to continue work. At this time, while at home, he suddenly became dizzy, lost consciousness, and was unconscious for a period of about forty-five minutes. He rested at home, was fairly comfortable, but continued to have shortness of breath on exertion. Three days and one day before entry he had attacks of unconsciousness lasting about a half-hour, followed by severe pain in the precordium, the neck and the left arm, and profuse perspiration, with cold, clammy skin. On entry he complained of these pains; severe headache and stiffness of the legs.

These attacks of loss of consciousness naturally arrest one's attention for a moment. He had three such attacks. What, in a cardiovascular history such as this, do they signify? Naturally, some cerebral accident, and from experience of my own I think I could say small hemorrhages, perivascular hemorrhages, following a spasm of one of the cerebral arteries, associated with the diapedesis of red cells, giving an injury which lasted but a short time. These later attacks, associated with Traunley's syndrome, are still more significant, and suggest another angiospasm in another region, coronary. So that cerebral angiospasm, coronary angiospasm, with interference with function of the brain and with further interference with function of the heart, are important points in that history. If I had to make a diagnosis at this stage, I would say that in a laborer of fifty-five we are dealing with arteriosclerotic heart disease, cerebral arteriosclerosis, coronary arteriosclerosis, but he might be a hypertensive. He is on the borderline, as far as age is concerned; but he is a laborer and we see more cases of arteriosclerotic heart disease among the laborers than we do of hypertensive cardiovascular.

Doctor Hall reports that, at physical examination, the patient's temperature was normal; his pulse was only 72, his respirations were 20, and he weighed 170 pounds. The blood pressure, on admission, was recorded as 160/110. General routine physical examination revealed a strongly built man, large frame, and powerful muscles. Poor dental hygiene. The heart was enlarged to the left, and there was a moderately loud systolic murmur at the apex. Pigmented scars over the anterior tibial surfaces—a laborer—so he was entitled to them. The reflexes were normal. The urine was negative, except for an occasional hyaline cast. There were no blood cells. The blood count was, to all intents and purposes, normal. Hemoglobin was 80 per cent, 4,500,000 reds, with normal leukocytes. His blood Wassermann was negative, so syphilitic heart disease, I should say hypertensive heart disease, is ruled out. My pathological friends may not agree, but I am not looking at the anatomical diagnosis now; I have forgotten it.

The electrocardiogram indicated coronary disease, and subsequent records taken during the next ten days confirmed this interpretation.

During the first five days in the hospital he complained of much pain in the precordium, neck, and both arms, but more severe in the left. Narcotics relieved the pain. Blood pressure rose to

180/70 (your printed report states it fell, which is evidently an error), and temperature remained normal. He continued to have occasional attacks of pain, but his condition improved gradually. Electrocardiogram tracings still presented evidence of coronary thrombosis.

I cannot accept that. I have never seen a case of coronary thrombosis with a blood pressure, whether it had risen or fallen, of 180/70. Everything is possible, of course, in medicine, but speaking from experience—for one has to speak from experience—that is not evidence of coronary thrombosis. I do not care what the electrocardiogram will show. I am old-fashioned enough, too well trained by Osler, to accept any laboratory dictum. I should not get annoyed about it, but if I am going to get annoyed about anything it is that—to have some smart alec come in and tell me that man has coronary thrombosis. I call it vigilance. (Laughter.) Mind you, I want electrocardiograms; I ask for as many electrocardiograms as anybody does, and I want the expert to say what he thinks; but that report goes into the positive column only through the negative column, just as the positive Wassermann or the negative Wassermann, the albumin urine, or what not. It is not a positive finding like tubercle bacilli in the sputum or typhoid bacilli in the blood, etc. It is a clinical finding of great importance, but I do not believe, and I ask you to think about it in the future, that it should be taken too seriously. Now, the electrocardiogram reported coronary thrombosis. The man had no fever, one of the symptoms of it. The leukocytes are not given at any particular time, but we are told that at one time they were 8,200. He had no leukocytosis. His blood pressure remained at a level of 180/70. No pericardial friction rub was heard. We do not expect that in more than 25 or 30 per cent of the cases. But that does not sound to me like coronary thrombosis. It sounds to me like hardening of the arteries disease, with angina and possibly a persistent angina, almost the status anginosus of Clifford Orbutt. These are the remarks I have to make about the case at this stage.

When he had been in the hospital about nine weeks, more interesting things developed. First, a low-grade fever, fluctuating between 99 and 101 degrees, and the pulse rate rose to 100. You recall his admission pulse rate was 72. The precordial pain had practically disappeared; of course, that would happen even in coronary thrombosis by this time. He developed, however, transient redness, swelling, pain, and tenderness in various joints of the extremities. I would like you to remember that, because I am going to refer to it in a moment. He developed an arthritis, or an arthralgia. His appetite became poor, he lost weight, his temperature became higher, a leukocytosis developed (18,000), the hemoglobin dropped to 60 per cent, and a blood culture on October 28 revealed *Streptococcus viridans*. And now we know that the patient has a septicemia due to the *Streptococcus viridans*, the organism so quickly associated with subacute bacterial endocarditis. Looking back to that development of fever, malaise,

loss of weight, and leukocytosis, plus the arthralgic symptoms, I could say at this point, if the case were mine, that this man has developed on top of an arteriosclerotic heart a subacute bacterial endocarditis, and his days are numbered. Blood and albumin appeared in the urine, whereas on admission they had been negative. Profuse perspiration, great loss of weight, and weakness developed. Acute pain, note, in the left upper quadrant of the abdomen, later in the right lower quadrant. Blood and albumin were found in the urine. With these episodes, which were of two to five days' duration, there was marked tenderness, but practically no increased rigidity over the abdominal wall in the region of the spleen or elsewhere. The systolic murmur at the apex did not change. During December, petechiae developed, not only in the skin but in the mucous membranes of the mouth and in the conjunctivae. We have the whole picture of subacute bacterial endocarditis, as first called to our attention by Manuel Lipman of Mount Sinai Hospital many years ago, and now a well-recognized clinical condition, just as well recognized as typhoid fever or tuberculosis.

He became semicomatose, developed signs of pneumonia, and died January 20, 1936, greatly emaciated, very anemic, and exhausted.

The diagnosis on entry, the report states, was hypertension, cardiac hypertrophy, and coronary thrombosis. Hypertension at 160? No! I disagree. That is not essential hypertension. That is the hypertension secondary to arteriosclerosis. Cardiac hypertrophy, yes; coronary thrombosis, no.

Then the final diagnosis of subacute bacterial endocarditis was made. It had been suggested that, since the heart murmur was only an apical systolic murmur and did not change throughout the course of the disease, there may have developed a mural thrombus in the heart which resulted from the coronary thrombosis which was suspected; a very plausible explanation—a very nice explanation. I agree with that, and say it was very smart, a good idea with the diagnosis of coronary thrombosis.

The terminal bronchopneumonia, the infarcts of the spleen and kidneys are of no great interest. The terminal bronchopneumonia is a terminal event in every acutely febrile case, and the infarction of the spleen and kidney is part and parcel to subacute bacterial endocarditis.

Now, ladies and gentlemen, we will hear what our friends, the pathologists, have to say, and I know that you do not need to tell them not to spare me or my blushes.

Report of the Pathologists:

DOCTOR HALL: Doctor Peers, Doctor Howard, Members of the Society: I am sure we shall not let Doctor Howard down very severely in this case.

. . . Doctor Hall reads autopsy report. . . .

COMMENT

DOCTOR HOWARD: I think you will agree we got off rather easily that time. I feel that the explanation for every symptom was there. Every

clinical laboratory finding was there in the autopsy, and the only thing that we have to criticize is the stress that was given to the report of coronary thrombosis by the electrocardiogram. The patient also should not have been considered a hypertensive. We will say more about that in the next case. It is too easily applied. A nurse can be trained to take a blood pressure, and if it is just a question of taking a blood pressure and calling a patient hypertensive, we should go out of business; certainly not spend four to eight years in training. I would suggest to you: never be satisfied with the diagnosis of hypertension and only after mature consideration, weighing the pros and cons, make a diagnosis of essential hypertension. So many other conditions may give rise to an increase in blood pressure of a moderate degree.

* * *

CASE 2

The second case is one that is much more unusual and very instructive.

The patient was a woman whose pathological findings Doctor Maner will discuss. Forty years of age, married seventeen years, and observed at the hospital from March 10 to March 17, 1934. Second admission, March 31 to April 1, 1934. She finally died at home on May 11, 1934.

The family history is negative.

The past history reveals a lot of infections. Scarlet fever is the most important one notoriously in relation to the kidney, and possibly some of you would overstress that from the subsequent developments. Some of you would say that this woman of forty at the age of three had acquired a glomerular nephritis which was eventually responsible for her terminal symptoms. Then so-called "typhoid malaria" at the age of eight; I place it in quotation marks because there is no such animal, as we all know. She had some infection at the age of eight, presumably typhoid. She also had, following this, measles in moderate severity, and then symptoms of frequency of urination, nocturia, and slight edema for several years. She was a multipara, had three children, all in good health. She had three abortions.

The present illness began two years before, coming under observation, with a stroke, causing partial paralysis of the left side of the face, the left arm, and the leg. After a few months she recovered and has since noticed only a slight weakness on that side. The diagnosis at that time was hypertension and nephritis. I have nothing to say to that. Also, of course, we could assume that she had a leak into her vein from an artery, resulting in that partial paralysis of the left side of the body. The systolic blood pressure at that time, two years ago, was only 200. Not marked; it was high. There was some polyuria as also nocturia.

About January 26, 1934, a second stroke occurred, involving this time the right side. She was taken to a hospital, where she remained about two weeks. During that time she had such severe headaches, nausea, and vomiting, that a spinal puncture was done to relieve the intracranial pres-

sure. A little later an osteopathic physician was consulted, and he was a good salesman and told the patient that she was suffering from a syphilitic brain tumor about the size of a walnut (it does not say with the shell on or without—I would like to know) in the posterior portion of the brain, which was pressing on the nerves, causing all her symptoms, *i. e.*, the headache, nausea, vomiting, high blood pressure, nocturia, etc. What is possibly more important is that the spinal fluid Wassermann was three plus.

Now, I would like to stop here. I would have been very much up in the air because here is a woman of forty, with symptoms of cerebral spinal disease and a spinal fluid which was three plus. Of course, it will not explain the hypertension, but one would naturally have to consider cerebrospinal vascular lues.

On March 3, 1934, the patient was brought to the office of another physician for verification of the osteopath's diagnosis. At this time all the symptoms of nausea, vomiting, severe headaches, were more severe, and she was beginning to complain of inability to see clearly, especially in reading. Hospitalization was advised and she entered the hospital again for diagnosis and the relief of her symptoms. At this time she was still fairly well nourished, extremely nervous, apprehensive, no doubt, lying in bed, with no evidence of dyspnea. Temperature was 99 degrees; respiration, 18; pulse, 110, full and bounding; blood pressure, 240/150. I think all agree that a diastolic pressure above 100 is a significant fact, and I think that at this point any one of us would be justified in saying, "Never mind the symptoms for the moment; we are dealing with malignant hypertension, anyway." What do I mean by malignant hypertension? But I know you know much more than two or three of my recent students who, in an examination on malignant hypertension which they were asked to discuss, said, in one case, "I know nothing about it; I have never heard of it." Another said, "I know so little about it, as apparently is true of Lewis, who has devoted only a small paragraph to the subject in his textbook on diseases of the heart." I did not take the trouble to verify that statement. I think it may have been true because Lewis is an electrocardiograph specialist. He is a physiologist and a cardiologist, but he is not a clinician, and he may not think that malignant hypertension is an important question. We in hospitals have to disagree with him. We believe it is a very important question.

Let me remind you that it was many years ago that Gullen Sutton pointed out that the most important thing about any disease was the arterial lesion, and when the sphygmograph was introduced by Bausch in 1893, a clinical instrument of great value was put on the market. The wonderful writings of Clifford Orbutt helped to interest the medical student in the problems of hypertension, and he it was who coined the term "essential hypertension." His two volumes on "Arteriosclerosis and Diseases of the Artery" are still classics. Thanks are due to Bolard and Farre, who pointed out that there was a group of cases which

might be termed truly malignant, and that the majority of cases of essential hypertension were benign. So that we began to think in 1914 of the benign and the malignant nephrosclerosis, those at least who had read Bolard and Farre's monograph. Later Farre suggested that the term "malignant" should be applied most emphatically to this group, and he would add the term "malignant nephrosclerosis," not merely malignant hypertension. His pathologic studies had so impressed him with the fact that the main suffering organ was the kidney that he said, "We will not speak of malignant hypertension alone. We will say malignant nephrosclerosis." Then, later in this country and elsewhere, Keith and Wagoner, studying a large group of cases, stressed even more so this lesion in the kidney described by Bolard and Farre, and even suggested that it is a distinct entity, that it is as much an entity as chronic glomerular nephritis, and that malignant hypertension does not develop merely as a result of essential hypertension of the benign type, but is malignant from the beginning of things. While I am not prepared to agree with that, I want to say that in looking over this history and the clinical findings to date, I would be inclined to regard this case now as malignant nephrosclerosis.

The examination of the patient was otherwise unimportant. The laboratory findings revealed a urine containing two plus albumin, rare hyaline cast, two to three red cells per high power field, and some leukocytes in this centrifugalized sediment. Other urine samples showed a specific gravity ranging from 1.015 to 1.017, an almost fixed specific gravity; no hematuria; no further casts found. So that we have evidence, then, of the malignant sclerotic disease. The blood count showed a slight reduction of the reds and the hemoglobin, a slight leukocytosis, and Wassermann tests were negative, as were Kahn tests. The spinal fluid showed marked increase in pressure, but only three cells. No increase in globulin. The next Wassermann was negative. The report does not say who took that spinal fluid that was sent before. I presume it was done in the hospital and, as often happens, the Wassermann is a false positive. Certainly, the examination subsequently of the spinal fluid rules out cerebrospinal vascular syphilis. The concentration test of the urine showed fixed specific gravity. A contracted kidney followed this. The blood chemistry showed retention of a moderate degree of nonprotein nitrogen. Uremia was impending. The treatment was the classical one of glucose intravenously daily, luminal sedatives, magnesium sulphate, and pancreatic tissue extract. I have never had any experience with that, so I cannot criticize.

The progress of the case was downward. The pulse ranged from 80 to 100; the blood pressure reached 256/190—it never fell below 172/130, and that was after intravenous glucose saline. Nausea and vomiting stopped. During the first few days, the patient was incoherent in speech and disoriented at times and very restless, as these patients nearly always are—apprehensive and restless as can be.

After a week she was allowed to go home. All nausea and vomiting ceased. Two weeks later she reported for another spinal puncture, with relief. The spinal fluid was not under the former high pressure, but the patient experienced marked relief from her headaches, etc.

From April to May 10 she was at home in bed, attended by a private nurse. During that interval she gradually became weaker, had a return of vomiting, and lost the sight of both eyes. No doubt, had a fundus examination been made at this time there would have been an extensive hemorrhagic uoretinitis, which in itself has its peculiar features and is so well recognized that our ophthalmologist often has the temerity to report malignant hypertension, nephrosclerosis, before we have made the diagnosis. Once he hurt our feelings very much in this, but we proved later to be right.

The patient finally died, so the diagnosis seems, to one who knows malignant nephrosclerosis of Bolard and Farre, to be a straight case of malignant nephrosclerosis. There is nothing more to say about it. The course of a few months is the usual one. The disease rarely lasts more than a year. It is to be separated entirely from secondary contracted kidney and from nephritis. It gives many symptoms that simulate the secondary contracted kidney, and very often one finds the condition adhering to that diagnosis in spite of the description of the other condition which I have just given you. We want you to bear that in mind—that there is such a disease as malignant hypertension, usually occurring in women and younger men, running a rapidly progressive course and ending in uremia, rapidly developed in the majority of cases, cardiac failure, or cerebral accident.

Now we are going to hear what the pathologic findings were. Doctor Maner.

Report of the Pathologist:

DOCTOR MANER: I may add that the Wassermann in this particular case that the doctor mentions was done by the osteopath. The necropsy here was performed by Doctor Foord, and was studied and presented by me through his courtesy. . . . Doctor Maner reads his report. . . .

✓ ✓ ✓ CASE 3

DOCTOR HOWARD: Doctor Budd will report on the third case which we selected. This was a young married woman of thirty-four, who had nothing of really great importance in her past medical history; measles, mumps, pertussis, chicken pox, etc. Her tonsils and adenoids were removed in 1921 for frequent sore throat. A severe bronchitis or bronchopneumonia occurred in 1932, from which the patient slowly recovered. There has been an intermittent fever with chills for the past eight years, and a diagnosis of malaria was made at one time. I am going to ask Doctor Budd afterward where she lived, and whether it was possible that she did have malaria at that time. Naturally, anybody remembering the Pel Epstein syndrome occurring in the later stages of Hodgkin's disease,

might think that that malaria-like fever could have been a Pel Epstein syndrome. I have known a case of Hodgkin's disease to last as long as that with a history of Pel Epstein syndrome eight years before, so I am more inclined to think that that intermittent fever with chills was probably a malaria, although it would depend upon the place of residence both in childhood and adolescence. She has had attacks of severe headache intermittently all her life, causing vomiting—migraine, in all probability—and of no interest. The patient has been very emotional, and her hair turned gray prematurely six years ago, at the age of twenty-eight. That is not an uncommon associated phenomenon in my experience with migraine. The family history is irrelevant. She complained, when she was admitted, of enlargement of the spleen, enlargement of the glands, loss of strength, loss of weight and appetite, and jaundice.

The illness dated back to April, 1934, when she first developed a painful lump in the left upper neck. There was a memory of a mild sore throat prior to this. The virus of Hodgkin's disease is usually supposed to enter through the nasal passages. Her general condition remained good until September of the same year, when three enlarged lymph glands were discovered in the left cervical chain. These glands were symptomless, and in February, 1935, one of them was removed for biopsy. The diagnosis reported by the pathologist was Hodgkin's disease. The patient remained in good health and continued to work, although she had a mild anemia and intermittent fever up to 101 degrees.

During March, 1935, high voltage x-ray therapy was given to the enlarged glands in the left neck, mediastinum, and upper peritoneal cavity and to the enlarged spleen. A prompt regression of glands occurred, with improvement in health and a gain of fifteen pounds in weight.

The blood count at this time, we are told, showed slight anemia, 80 per cent hemoglobin, with a leukopenia of 4,300, but that leukopenia was peculiar because, contrary to most leukopenias, the polymorphonuclears were relatively increased—79 per cent. Small lymphocytes were only 11; large lymphocytes, 1; transitional cells, possibly the only significant thing in the differential, 5; eosinophils, 3; and basophils, 1. The picture is one that is quite in keeping with Hodgkin's disease. Its negative Wassermann exists habitually, and the most peculiar thing was the leukopenia with polymorphonuclears in regard to this.

The patient remained well until August, 1935, at which time examination revealed the eyes, nose, and throat to be normal; teeth sound; and chest, heart, and lungs normal. Two indurated glands were found in the right axilla and one in the left axilla. There was an abnormal resistance in the epigastrium from an obvious retroperitoneal mass of undetermined size. The liver and spleen could not be felt. Shotty glands were present in both groins of only suspicious character.

Radiographic studies of the ribs, lungs, and mediastinum failed to reveal any evidence of abnormal pathology.

The blood count then revealed a hemoglobin of 64 per cent, a drop; reds of 4,290,000; whites of 4,900; and no malaria parasites could be found. She had a further x-ray treatment.

The patient remained in good health until the first part of December, when she began to suffer with severe headaches, a fever of 101 degrees, and greatly increased jaundice. That, of course, is an unusual feature, and at once attracts one's attention. I feel certain that we would suspect, as sometimes occurs in so-called abdominal Hodgkin's disease, involvement of a group of glands somewhere near the common duct and pressing on the common duct, and resulting in an obstructive jaundice. Loss of appetite and strength and weight persisted.

The blood count on January 6 showed a further drop, 22 per cent; reds, 1,410,000; and the whites were still lower, 1,500. Differential count showed that same polymorphonuclears predominance, 95, of which 3 were juvenile, 20 stab, and 72 were the ordinary segmented forms; monocytes, 3; plasma cells, 1; and myelocytes, 1. The red cells were of varying size and shape. The average size of the cell was approximately normal. There was a moderate poikilocytosis. There was some polychromatophilia. There was a complete absence of lymphocytes, with a marked left shift in the polymorphonuclears. The platelets were now distinctly reduced in number. Of course, she had had so much x-ray therapy one might very well expect that. My only regret is, from what I have read about the case, that we do not know what the platelets were when she first came under observation. As many of you know, Buerke of Madison, Wisconsin, many years ago, when he was still an assistant in pathology to Welch and Hopkins, found and stressed the frequency of an increased platelet count as a feature of Hodgkin's disease; and we have accepted that at its face value. We do not rule out Hodgkin's when it is not present, but it is very, very frequently present. If I were to have a blood report on the case, as I naturally would like in every case, I would rather have the platelet than anything else. There is nearly always in the early stage, before x-ray therapy or radium therapy has been instituted, an increase in the platelets. The urine was reported as negative except for the urobilin much increased, urobilinogen also increased, and the stool examination was negative.

The patient was finally hospitalized with the hope of controlling the nausea. The blood counts revealed further anemia. The direct Van den Bergh showed an immediate heavy positive; indirect Van den Bergh, 16 units. She was given blood transfusions at weekly intervals without apparent benefit. The stool examination remained normal. On January 25 the blood count was still further reduced: 19 per cent hemoglobin, 880,000 reds, white blood cells 1,400; and there were 9 lymphocytes now. The jaundice was extreme and the patient was irrational. There was marked edema of all the tissues, and the liver and spleen now both reached two fingerbreadths below the costal margin. She died on January 26, 1936.

Of course we had the biopsy, which we should have in every case. If you ever miss Hodgkin's disease it is your own fault, because early in the disease a biopsy should be done. Now to confess the truth, in spite of my knowledge of that, I missed a case of Hodgkin's disease in a young Irish-Canadian woman who was the picture of tuberculosis: the dark swarthy type, with hair on her forearms and legs, emaciated, having glands in the neck, a cough, a mediastinal dullness, and an x-ray plate which showed plainly the mottling of the lung and calcified areas of the tracheo-bronchial type of an early childhood tuberculosis. The clinician told me that she had a positive Von Pirquet of one to ten thousand. She had a little fever, she was sweating, and she had all the symptoms of tuberculosis of the lungs. She was coughing, but no tubercle bacilli could be found. We advised sanitarium treatment, but she did very badly under it. She was sent home by the sanitarium physician, a wise man, saying that this was not tuberculosis; it was Hodgkin's. When she came home we had, then, to my shame, what I should have ordered before, a biopsy, and it was Hodgkin's. She is dying now from Hodgkin's. So, in any suspicious case, as this case well illustrates, a biopsy will make the diagnosis because—as Dorothy Reed McCallum pointed out long ago; Sternberg, too, of course—there is a histologic picture in the glands that occurs in no other condition, whether or not you accept the Dorothy Reed specificity or the Dorothy Reed cell. Whether you accept it or not, there is a combined histologic picture which I think cannot be questioned, and the histologists in this country are perfectly ready to accept it and to make a diagnosis for you early, as early as the gland is submitted. Doctor Foord is going to discuss this case.

Report of the Pathologist:

DOCTOR FOORD: Mr. Chairman, Gentlemen: The interesting thing to me was the profound anemia which came on six months after x-ray was stopped, and in our postmortem I think we can explain some of the causes.

. . . Doctor Foord reads his report.

COMMENT

DOCTOR HOWARD: Now, ladies and gentlemen, we got a surprise there in the finding in the bone marrow. It is, I am sure, clinically a very rare event and also pathologically, as far as my case could go. I recall only one similar case in which the bone marrow was so extensively involved, so our interpretation of the absence of platelets and the low blood count of progressive anemia as due to possible over-x-ray radiation was not justified, and Doctor Foord has given you the explanation in the destruction of the hematopoietic system by invasion of Hodgkin's tissue.

IN CONCLUSION

You have been very kind and considerate, but my time is up and I am going to ask the privilege of calling it a day's work. Doctor Budd had a very interesting case of acute lymphatic leukemia

for us, but as it is half-past twelve and I know you are tired we are going to close the discussion. (Applause.)

• • •

PRESIDENT PEERS: One moment, please. I think your chairman should express his great pleasure at the success of this conference. I think that this innovation, which has been introduced by the Program Committee, has been a wonderful success and it has been due to a number of factors. First, we have had a number of men who have given a great deal of time to the preparation of this program and worked the cases up well and had autopsy reports. Then, in addition to that—and here is a suggestion for any future programs of this sort—we hope that you can get a leader with the great experience and the wide knowledge and keen analytical mind of the gentleman who presided this morning at this conference. If you could get one with the same kindly humor and charming manner of delivery as our friend here, I am sure that the next conference of this sort will be a great success. I thank you, Doctor Howard, and I thank all the members of and leaders in this conference for the splendid work they have done in making such a wonderful success of the morning. Thank you very much. (Applause.)

. . . The meeting was adjourned by President Peers.

PROTAMIN INSULIN: SOME CLINICAL STUDIES

CALCIUM AND ZINC PREPARATIONS WITH INSULIN

By BERTNARD SMITH, M.D.

AND

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Los Angeles

THE studies comprising this report are a continuation of those previously reported on the use of simple protamin insulin,¹ and are concerned with mixtures of calcium and zinc in the precipitated insulin, including the present zinc series of the more stable mixed form.* A total of 174 patients have been under observation with protamin insulin therapy, and 150 are included in this report. Of these, eighty-eight patients are adults and sixty-two are juveniles, with an age range from 18 months to 79 years. Forty-five patients have been hospitalized for a closer study at the beginning of protamin treatment. Daily urine analyses were made on these patients. Ambulatory patients have been seen once a week, with analyses of urine on each visit. Urines have been routinely collected in two twelve-hour periods to cover the full twenty-four hours immediately before the visit, and the daily analyses for all hospitalized patients have been collected in the same two

* All preparations of protamin insulin used in these studies have been supplied by the Eli Lilly Company, and appreciation is now expressed for the courtesy and generosity this company has shown throughout the work.

All clinic patients selected for this study are from the diabetic services of the Cedars of Lebanon and Children's hospitals. The interest and coöperation shown by the various staffs of these institutions have been of great help.

periods of each day. Blood-sugar tests have been done for certain studies, but these have been no part of the regular routine.

PROTAMIN INSULIN AND INSULIN ABSORPTION

In the studies with simple protamin insulin it was found that the rate of insulin absorption varied with the different patients, and even in the same patient under certain conditions. The same is seen in patients included in this study, and becomes important in the determination of proper time and unit strength of dosage of the present precipitated insulin. This individual problem is the more difficult in those diabetic patients who have been using the regular insulin for some years, and the disturbance to the diabetic control with these patients is often marked immediately after the change to the precipitated protamin insulin.

Of the 150 patients, 113 are grouped as either insulin sensitive or insulin resistant. Identification of these two types appears to be more definite under protamin insulin treatment than under regular insulin. The characteristics of the two groups have been described^{2,3,4} and need not be given in this report. However, the identification of the two groups seems to be of no little importance in protamin insulin therapy in both routine of treatment and in prognosis. Members of the insulin resistant group—insulin wasters⁵—are always severe diabetics, but this is not necessarily true of the sensitive group. The following classification covers the 150 patients:

Severe	79
Moderately severe	63
Mild	8
Insulin sensitive	62
Insulin resistant	51

Some influence from the previous studies with simple protamin insulin may have been carried over into these later studies, and is an explanation of the seemingly routine habit of prescribing two daily doses of protamin insulin. With both the calcium and the zinc mixtures, these injections have been taken at some definite time rather than in relation to meals, as has been usual with regular insulin. No attempt has been made to prescribe routinely both regular insulin and protamin insulin.

For convenience, the abbreviations R-I for regular insulin, and CaP-I and ZP-I for the two preparations of protamin insulin will be used in the text which follows.

THE ADJUSTMENT PERIOD

In beginning P-I treatment, the early weeks must be given to a determination of the individual absorption rate and the problem of timing the dosage to the best advantage of the patient. This adjustment time may take several weeks, and is referred to in the tables as first period. It is important in this adjustment period to make all insulin changes carefully and not too frequently, or a continued loss of diabetic control will result. At the present time only twelve patients are taking both R-I and P-I. Eight of these take a morning injection of R-I, and both morning and evening doses of P-I; two take one dose of R-I in the morning and one of P-I in the evening; two take

one injection each of R-I and P-I in the morning. Six patients continue at present to use CaP-I. These patients are well controlled. The change from CaP-I to ZP-I may cause a high percentage of glycosuria or some disturbing degree of hypoglycemia, and it has been found necessary to make the shift from the calcium mixture to zinc gradually, and with close observation of symptoms and laboratory analyses. With the present zinc preparation that is supplied already mixed, there may be seen occasional loss of diabetic control in changing from one letter series to another, or from one bottle to another in the same letter series. Some considerable part of this loss in control may be due to faulty shaking of the bottle before the insulin dose is withdrawn. The precipitate in the bottle will settle out when the bottle stands upright, and an even distribution will not be obtained if the shaking is faulty.

TABLE 1.—Comparison of Diabetic Control

	R-I Per Cent	First Period. Per Cent	Present. Per Cent
Good	13.6	36.6	64.0
Fair	32.4	36.0	29.4
Poor	54.0	27.4	6.6

COMPARISON OF DIABETIC CONTROL

Table 1 gives a comparison of diabetic control for the entire 150 patients. The term "good" has been used to indicate a loss of sugar of ten grams and less in twenty-four hours. The term "fair" indicates a loss of ten to forty grams. Good to good indicates a good control maintained. Table 2 gives a comparison of control and of insulin dose between R-I and CaP-I, and is based on the eighty patients who began using the calcium mixture.

TABLE 2.—Comparison of Control and Dose

R-I and CaP-I			
Control.	Per Cent	Dose.	Per Cent
Improved ..	52.5	Increased ..	47.4
Unimproved ..	20.0	Same ..	32.6
Worse ..	18.5	Less ..	20.0
Good to good ..	9.0		

INSULIN EFFECT OF PROTAMIN INSULIN WITH CALCIUM PREPARATIONS

The insulin effect of CaP-I is not as prolonged as with the zinc preparation. Some part of the unsatisfactory control shown in Table 2 may be due to this shorter duration of insulin effect. Could the eighty patients have been limited to those who absorbed the precipitated insulin more slowly, the percentage of those showing poor control might have been reduced. A comparative duration effect of insulin from CaP-I and ZP-I is given in Table 3 as blood-sugar analyses. This patient, age forty-four years, required three daily injections of R-I for control. He has remained in good control, with continued sugar-free urines, for nearly six months on one injection of ZP-I a week, and shows a hyperglycemia when the interval between insulin injections is from ten to fourteen days. The case is unusual and the patient will probably require daily doses some time in the future.

TABLE 3.—Duration of Insulin Effect

Blood Sugars Date		CaP-I and ZP-I			
		Time			
	Fasting	9 a.m.	11 a.m.	3 p.m.	
July 23.....	136	138	106	158	July 22. Twenty unit dose of CaP-I given.
July 24.....	135	152	128	163	
July 25.....	148	182	170	200	
July 29.....	154	164	174	136	July 28. One 16 unit dose of ZP-I given.
July 30.....	105	134	121	145	
July 31.....	123	160	148	207	

INSULIN ABSORPTION PROBLEM

Since the degree of diabetic control obtained with protamin insulin depends largely on the rate at which each patient absorbs the insulin, this absorption problem becomes of great importance when the precipitated insulin is given twice daily, and the most favorable time for the two injections can be determined only when the rate of absorption is known. Somewhat routinely in these studies, the interval between morning and evening injections has been twelve hours at the beginning of protamin treatment. The morning dose has usually been taken before breakfast and the evening dose twelve hours later, which is often after the evening meal. On this routine severe hypoglycemic reactions may occur between midnight and breakfast, usually between 3 and 6 a. m. The food plays considerable part in protecting these patients from reaction symptoms during the day, but the usual bedtime food does not give protection throughout the night. These patients appear to be absorbing insulin from the dose of the previous morning, and to be beginning to receive effective insulin from the evening dose as well. This gives an overlapping period from excess insulin during the night. The reaction symptoms may clear entirely by taking the evening insulin one or more hours later, or by reducing the unit strength of the morning injection.

DOSE ARRANGEMENT

In Table 4 is seen the changes in dose arrangement as at present compared with the end of the first period. These changes give some indication of the individual nature of the problem.

TABLE 4.—Changes in Unit Dose Arrangement

	First Period.	Present.
	Per Cent	Per Cent
Larger dose in morning.....	37.4	4.7
Larger dose in evening.....	16.6	27.2
Equal morning and evening doses.....	15.7	24.6
Single dose.....	30.3	43.5

CONTROL AND DOSE COMPARISONS: UNDER
DIFFERENT METHODS

In Table 5, the improvement at present over the condition at the end of the first period is mainly due to an avoidance of frequent changes either in time of injections or unit strength of dose. The changes in time of the injection when two daily doses of protamin have been prescribed more often concerns only the evening dose, since the morning injection time is more or less fixed. After any change in time of dose there must be allowed sufficient period for the patient to adjust to the change before another break in the routine.

TABLE 5.—Comparison of Control and Dose

A. Comparison of End of First Period and Previous Regular Insulin			
Control	Per Cent	Unit Dose	Per Cent
Improved	50.3	Increased	44.9
Unimproved	32.6	Same	38.8
Worse	6.8	Less	16.3
Good to good.....	10.3		
B. Comparison of Present and End of First Period			
Improved	25.3	Increased	24.0
Unimproved	24.7	Same	56.7
Worse	4.7	Less	19.3
Good to good.....	45.3		

TERMS OF CONTROL: UNDER DIFFERENT
METHODS

The results in terms of control are seen in a comparison of present conditions with the control formerly obtained with regular insulin, and this is shown in Table 6.

TABLE 6.—Comparison of Control

Present with Former Regular Insulin		Per Cent
Improved		74.0
Unimproved		11.4
Worse		3.3
Good to good.....		11.3

ADVANTAGES OF LESSER NUMBER OF
INJECTIONS

The fewer injections required daily with the precipitated insulin is of definite advantage to the diabetic patient in school or at work. Such comparison of number of daily doses between regular insulin and present protamin insulin is given in Table 7.

TABLE 7.—Comparison of Number of Injections

Daily	1	2	3	4	4 plus.	Weekly
Regular insulin	6	83	47	13	1	
Protamin insulin	67	82	0	0		1

COMPARISON OF CONTROL: R-I AND PRESENT

A comparison of control of the present with former R-I is given in Table 8, in which the control is shown by a compared unit dosage of insulin. In the classified portion of the table are included the two types of insulin sensitive and insulin resistant. That the insulin resistant type comprises over 50 per cent of the cases that have required an increase in unit dose, gives some idea of their severity and the difficult problems they present.

COMPARISON OF THE NUMBER OF DAILY
INJECTIONS

In Table 9 is shown a comparison of the number of daily injections of R-I and P-I by classified groups. It is seen in this table that many of the insulin sensitive group are able to maintain diabetic control on one injection of protamin insulin daily. With the insulin resistant group this has been true of five patients out of fifty-one. Twelve of the twenty-seven insulin sensitive patients who took two doses daily of P-I at the time the data

TABLE 8.—*Classified Control Comparison*

	R-I and Present		Per Cent
	No.	Classified	
1. Less unit dose:			
Improved	27	Mild and moderately severe.....	44.4
Unimproved	1	Severe	55.6
Worse	0	Insulin sensitive	61.0
Good to good.....	8	Insulin resistant	1.9
2. Same unit dose:			
Improved	36	Mild and moderately severe.....	67.9
Unimproved	5	Severe	32.1
Worse	1	Insulin sensitive	34.1
Good to good.....	5	Insulin resistant	21.2
3. Increased unit dose:			
Improved	50	Mild and moderately severe.....	33.8
Unimproved	8	Severe	66.2
Worse	4	Insulin sensitive	28.2
Good to good.....	5	Insulin resistant	50.7

was compiled have now been changed to one daily dose, leaving a total of fifteen of the group who take two doses daily.

TABLE 9.—*Comparison of Number of Injections*

Arranged by Groups						
R-I and P-I						
Daily Insulin Injections	1	2	3	4	4 plus	Weekly
Severe	{ R-I 0	26	44	8	1	
	{ P-I 11	68	0	0	0	
Sensitive	{ R-I 0	39	28	1	0	
	{ P-I 35	27	0	0	0	
Resistant	{ R-I 0	12	31	7	1	
	{ P-I 5	45	0	0	0	1
Mild and mod- erately severe	{ R-I 3	57	6	0	0	Five had
	{ P-I 55	16	0	0	0	had no R-I

A comparison of control for the same group classification is given in Table 10.

TABLE 10.—*Comparison of Control by Classified Groups*

R-I and P-I			
		R-I	Present.
		Per Cent	P-I Per Cent
Insulin sensitive.	62 Cases.		
Good		25.8	70.7
Fair		38.0	25.9
Poor		36.2	3.4
Insulin resistant.	51 cases.		
Good		1.9	41.1
Fair		15.7	47.2
Poor		82.4	11.7
Severe.	79 cases.		
Good		3.8	50.6
Fair		15.2	40.5
Poor		81.0	8.9
Mild and moderately severe.	71 cases.		
Good		24.7	76.0
Fair		50.0	22.5
Poor		25.3	1.5

PROBLEMS OF SEVERE DIABETICS NOT ALL SOLVED

It is evident from the tables that the problems of the severe diabetic are not all solved at the present time with the new protamin insulin treatment. However, even in the more difficult resistant group, diabetic control has been more satisfactorily maintained than under former regular insulin therapy. It is possible that the experience obtained with long periods of use will improve the routine of protamin insulin treatment, and give a clearer understanding of the more complex problems that enter into the picture of the more severe types of the disease.

JUVENILE DIABETES: STUDIES

Of the sixty-two juvenile diabetics studied, none have diabetes of mild degree. There are thirty-six severe and twenty-six moderately severe cases. Of the severe group, twenty-five are of the insulin resistant type; and of the entire group, thirty-one, or 50 per cent, are insulin sensitive. Thirty-three patients in this juvenile group take two doses of P-I daily, and six of these take regular insulin in addition. Of this group of thirty-three patients, twenty-two are insulin resistant. Twenty-nine of the juvenile cases are on one dose of P-I daily. Of these, three are wasters, one of whom takes a morning dose of R-I and an evening dose of P-I. We are interested in the group of juveniles ten years of age or under, particularly as to their ability to be controlled on one injection of insulin daily. There are twenty-two patients in this age group, and seventeen of these now take a single P-I dose. None of these seventeen cases are listed as insulin resistant, but sixteen are insulin sensitive. The five patients of this group who are on two doses daily are all insulin sensitive.

TABLE 11.—*Comparison of Diabetic Control*

Juvenile Group. Sixty-two Cases			
		R-I	First Period.
		Per Cent	Per Cent
Good	16.1	38.8	40.3
Fair	32.2	32.3	46.8
Poor	51.7	28.9	12.9

A comparison of diabetic control in the group of juvenile diabetics is shown in Table 11. There have been six cases of coma and six of severe ketosis in six patients during the months of protamin insulin study. All have been treated with a combination of regular and protamin insulin. The usual routine has been to give both R-I and P-I at the beginning of treatment, and continue with frequent doses of R-I until there is clinical improvement and laboratory analyses indicate satisfactory control. Our impression has been that the duration of the acidosis is lessened and, more important, that the period of instability, which usually appears after adequate treatment with R-I, is less pronounced and of shorter duration.

ARTERIOSCLEROTIC GROUP

There are twenty-four patients of the arteriosclerotic group in the total cases studied. Eight

of these are insulin resistant and two are insulin sensitive. Seven patients have coronary sclerosis, and five of these have had definite attacks of angina. Four patients have had at least one cerebral hemorrhage. All of these patients except three have a severe degree of diabetes, and the three are of moderate severity. All have held a good control after the first period of adjustment except three, and these remain as difficult problems with P-I as they were on former R-I therapy. Three deaths have occurred in the entire group of 150 patients during the months of P-I study, and these all belonged in this arteriosclerotic group: one death from myocarditis, one from coronary thrombus, and one from advanced cerebral sclerosis. It is realized that no definite conclusion can be based on results of a study carried through for so short a time; but it is our impression that those patients of this group with anginal pain have had less frequent attacks, and that the pain has been less severe.

PROTAMIN INSULIN IN PRE- AND POSTOPERATIVE CARE

Experience with protamin insulin in pre- and postoperative care has been too limited for definite conclusions. With the few surgical patients for whom protamin insulin has been used, the maintenance of diabetic control after prolonged anesthesia has been very satisfactory. Only three cases have been observed and these are moderately severe diabetics. One patient received a single dose of ZP-I at the time of a midnight feeding, with early morning surgery following. Two received a single dose six hours before operation. All were adults and held full diabetic control after surgery for twenty-four hours without additional insulin.

SUMMARY

It is realized that conclusions on the results of protamin insulin treatment must be based on observations of less than one year. Also, some considerable part of the improvement here recorded might have been obtained with regular insulin therapy if the same close observation were followed, with the better degree of coöperation that could have resulted.

In the entire group of 150 diabetic patients now reported, the attempt in these studies has been to substitute one or two daily doses of protamin insulin for any number of doses of regular insulin that had been taken before, without making any change in the diet values or in the arrangement of meals in any way, except the addition of a night feeding when this had not been taken previously.

The entire group of patients included in this study have been problem cases, and were selected for this study because of the difficulties in maintaining satisfactory diabetic control with regular insulin.

Even in the mild and moderately severe diabetic patients, protamin insulin can give satisfactory results only when the problems of technique are approached as individual problems for each patient. As great a difference in individual absorption rate will be found in the mild as in the most severe patient.

In deciding the unit dose of protamin insulin, it must be kept in mind that the insulin has a U-40 strength. To secure the full unit dose prescribed it is necessary that the bottle be gently shaken in order to have an even distribution of the sediment, which contains an important part of the insulin dose.

Early morning hypoglycemic reactions are often due to an overlapping insulin effect, insulin from the injection of the previous morning and from the evening being actively absorbed at the same time. At the beginning of protamin insulin treatment, reaction symptoms may appear at irregular times during the day and night. These may be due to conditions of adjustment to the slow and gradual absorption of insulin, and appear to be more disturbing in those patients who have used regular insulin for several years. Close observation of these patients during their period of adjustment is important.

The recognition of patients who are classed either as insulin sensitive or as insulin resistant is important. The insulin sensitive patient appears to become more completely adjusted to a slow absorption of insulin and more able to maintain a diabetic control on one daily dose. In the 150 diabetic patients, over 56 per cent of the insulin sensitive group have been able to continue on one daily dose of the protamin insulin, as compared with 29 per cent among the insulin resistant cases.

1930 Wilshire Boulevard.

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CARDIOSPASM*

By H. BRODIE STEPHENS, M.D.
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DISCUSSION by F. P. O'Hara, M.D., San Diego; John Hunt Shephard, M.D., San Jose.

CARDIOSPASM is the term used to describe that clinical condition characterized by a difficulty in swallowing, caused by an obstruction at the lower end of the esophagus in the region of the diaphragm. Despite the severity of the obstruction observed during life, though dilatation and hypertrophy of the esophagus are still present at necropsy, no obstruction can be found distal to the dilatation. Whatever the cause of obstruction during life, it ceases to act after death.

SUGGESTED HYPOTHESES

Many hypotheses have been suggested to account for the obstruction. These can be con-

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Read before the General Surgery Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25 to 28, 1936.

TABLE 1.—On Ten Patients With *Cardiospasm**

Initials	Age	Sex	Symptoms and Duration	Treatment		Symptomatic	Results	
				Type	Number			X-ray Appearance
I. C.	29	F.	Vomiting after eating, eight years.	Plummer dilatation, July to December, 1931	Several	Weight: 53.8 kilograms, 1931 Weight: 74.5 kilograms, 1935 No complaints, 1935		Dilatation with angulation in 1935; only dilatation in 1931.
P. G.	39	M.	Thought to have a carcinoma; considerable weight loss, several months.	Plummer dilatations, September, 1934..... July, 1935.....	4 5	Weight: 66 kilograms, 1934 Weight: 84.6 kilograms, 1935 No complaints		Dilatation of esophagus and spasm still present; slightly less than before treatment.
L. F.	60	F.	Difficulty in swallowing food, three years. Peptic ulcer, 1927, cured medically.	Esophagoscopy and bougie dilatations, July, 1933.....	4	Weight stationary. Very few symptoms. Improved by esophagoscopy, inadequately treated. Esophagoscope entered stomach easily in January, 1936.		Progressive increase in size of esophageal dilatation.
N. G.	33	M.	Recurrent attacks of vomiting, three years.	Esophagoscopy and Plummer dilatations, September, 1933..... October, 1933.....	5 2	Weight stationary. Fifty per cent improved two years after treatment.		Marked dilatation of esophagus before treatment. Slight improvement after five dilatations. Good case for operation, but patient refused.
R. B.	40	M.	Burning pain under the sternum, and loading up of food in the esophagus, relieved by vomiting, two years.	Esophagoscopy and Plummer dilatations, July, 1935..... December, 1935..... January, 1936.....	5 2 1	Twelve pounds gain in six months. Eating everything after eighth dilatation. Result: good.		Moderate improvement; question of duration, however.
R. D.	27	M.	Vomiting after eating, two years. Thirty pounds loss of weight.	Esophagoscopy and Plummer dilatations, January, 1933..... February, 1933.....	2 1	Ten pounds gained in two years. Paroxysmal attacks of difficulty in swallowing. Result: good.		Esophagus dilated three times normal size two years after incomplete treatment. Symptoms paroxysmal. Treated in psychiatric clinic.
M. R.	28	F.	Difficulty in swallowing, eleven years. Tube-fed for two years.	Esophagoscopy and Plummer dilatations; local application 25 per cent silver to ulcer at cardio-esophageal junction March to August, 1932..... January to February, 1933.....	8 2	Forty pounds gained in two years. No difficulty in swallowing. Clinical result excellent.		One year after dilatations instituted, x-ray shows esophagus much less dilated. Slight spasm with slight delay.
A. P.	42	M.	Difficulty in swallowing solid foods, four years.	Esophagoscopy and Plummer dilatations, October 8, 1932, to March 18, 1933.....	26	Twenty pounds gain in three years. No symptoms except for delay when excited or angry. Clinical result excellent.		Very slight delay three years after treatment. No dilatation of proximal esophagus. Good x-ray result.
A. E.	47	M.	Vomiting after meals, six months. Loss of weight, 35 pounds.	Esophagoscopy. Dilatations	None	Sixteen pounds gain in three months. Marked improvement by one esophagoscopy.		Esophagus dilated twice normal size. No change after esophagoscopy.
H. W.	56	M.	Regurgitation of food recently eaten, four years.	Esophagoscopy and Plummer dilatations, October 27, 1935, to November 19, 1935.....	9	Six pounds gain in three months. Clinically much improved.		After nine dilatations, esophagus still markedly dilated.

* Summary of Table 1: Number of males, 7; number of females, 3; ages, 27 to 60 years. Duration of symptoms, several months to 11 years. Clinical results, all improved clinically. X-ray appearance: Two showed decrease in size of esophagus by x-ray; eight were the same or worse.

veniently considered according to whether they postulate changes in the esophagus itself or in adjacent structures. In the latter group are included those cases possibly caused by kinking of the esophagus because of a deformity of the esophageal groove on the posterior surface of the liver (Mosher¹); an incoördination of the normal movement of the diaphragm during deglutition, with perhaps an actual spasm of the diaphragm (Jackson²); obstruction resulting from the action of the phrenico-esophageal membrane (Fulde³).

Hypotheses based upon changes occurring primarily in the esophagus center chiefly upon incoördination of the nervous mechanism of the cardia. Hurst⁴ assumes that there is a paralysis of the mechanism of the vagal opening. In Walton's⁵ opinion there is no paralysis, but rather a spasm in the region of the cardia. The difference in their views is well illustrated in relation to the passage of bougies. Hurst declares that a bougie will always pass the sphincter readily, without resistance; Walton, that the bougie is firmly gripped by the sphincter in its passage. It has been my experience that either bougie or esophagoscope will always pass through into the stomach readily. If either of these views is correct, there must exist at the cardia a true intrinsic sphincter, the tonus of which may be modified by the action of the extrinsic nerves.

KNIGHT'S STUDIES

Knight,⁶ working upon cats because the esophageal structure corresponds most closely to that of the human being, demonstrated that the interdiaphragmatic and intra-abdominal portions of the esophagus function as a true intrinsic sphincter, which is relaxed by the vagus nerve and contracts on sympathetic stimulation. The sympathetic supply arises from the celiac plexus in fibers that follow the course of the left gastric artery and its esophageal branch to the lower end of the esophagus. Knight was able to show definitely that bilateral vagal section reproduced the roentgen, pathologic, and clinical picture of achalasia of the cardia. The sphincter failed to relax. (Ferguson⁷ obtained similar results in monkeys while studying the effects of vagotomy on the gastric function.) If, however, celiac sympathectomy with a consequent denervation of the sympathetic fibers was performed at the same time that the vagi were divided, no obstruction resulted at the cardia; the sphincter always relaxed to allow the meal to enter the stomach. Knight concluded that whether the obstruction was caused by failure of the vagus or by spasm, in either case the integrity of the sympathetic supply is necessary for the obstruction to occur, and therefore it could be relieved by sympathectomy.

CELIAC SYMPATHECTOMY

At the time of Knight's report (January, 1935), seven patients had been subjected to the operation of celiac sympathectomy for the cure of cardiospasm. It was then too early for a complete report of the follow-up studies.

Accurate follow-up studies of the cases of cardiospasm treated by various means of dilatation are infrequently found in the literature. Knight's chart of sixty-six collected cases is surprising because of the high number of failures resulting from treatment by the various forms of dilators.

Knight's findings are substantiated by our study of ten patients, so far as the x-ray studies after dilatation are concerned (Table 1). The most noteworthy observation in these patients studied in our clinic is the marked symptomatic improvement, accompanied by gain in weight immediately following the institution of dilatation, by the Plummer dilator. Before undergoing this treatment the patients were observed both by the fluoroscope and the esophagoscope.

All of our patients were so much improved symptomatically following one or several dilatations that none of them was sufficiently uncomfortable to desire operative treatment.

COMMENT

The negative findings at necropsy in patients suffering from cardiospasm, together with the experimental observations up to the present time, point to a neurogenic origin for this clinical entity. The presence of a true sphincter at the cardio-esophageal junction is necessary for this theory to be tenable. Knight believes that he has shown a true sphincter to be present in the cat.

The condition of cardiospasm, whether resulting from vagal failure or sympathetic overstimulation, theoretically should be relieved by sympathetic interruption.

It has been shown in our own patients that dilatation by the various methods will bring about symptomatic relief in a high percentage of cases, yet the delay in the esophagus is still present. The symptoms of cardiospasm characteristically recur following dilatation, and are usually relieved by further dilatation. There has been no adequate explanation for the symptomatic relief obtained by the use of dilators, without appreciable change in the x-ray appearance of the delay at the region of the cardio-esophageal junction.

CONCLUSION

The operation of interruption of the sympathetic fibers running to the lower end of the esophagus from the celiac plexus, as suggested by Knight, is recommended for consideration in those patients with cardiospasm not relieved by dilatation. All of the patients in our series were improved sufficiently by dilatation so that operative intervention was not required.

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DISCUSSION

F. P. O'HARA, M. D. (505 Medical-Dental Building, San Diego).—Most investigators consider cardiospasm to be due to some change in the nervous control over the esophagus. Many men have been seeking for some more adequate method of treatment than the dilatation of the cardia by mechanical means. Forcible dilatation no doubt relieves symptoms in a great number of these cases, but it has been found that these symptoms return and the actual deformity, as shown by x-ray, is unchanged. The work of Knight seems a definite step forward, and although it has not been tried in this country it deserves thoughtful consideration. We have found it difficult, so far, to persuade patients suffering from this condition to be operated upon, but think that time will soon make a change. It is a rather simple operative procedure, and its etiologic basis seems sound. Certainly, in some of the cases which have gone on for ten to twenty years, in spite of other forms of treatment, this procedure should seem advisable.

I have been particularly interested, not so much in cardiospasm, but in the "esophagismus" at other levels in the esophagus where we find spasm that will yield to simple repeated dilatation. In practically all of these cases it has been observed that there is a coexisting, rather localized arthritic spurring of the spine at the same level. Whether this condition may be stimulating the sympathetic innervation of the esophagus producing the spasm is merely conjecture, but I should be curious to know if other men have observed this same condition in cardiospasm.



JOHN HUNT SHEPARD, M. D. (608 Medico-Dental Building, San Jose).—The apparent infrequency with which a diagnosis of cardiospasm is made is, I believe, due to the fact that this clinical entity is not kept in the foreground of our minds. Some dysphasia is always present, and whenever a patient complains of dysphasia, substernal distress or discomfort in swallowing, or the eructation or vomiting of food free from any evidence of gastric digestion, an x-ray examination of the esophagus should be had, and if the roentgenologist is informed of the clinician's suspicion and uses a barium-acacia mixture in his examination, he will readily prove or disprove the presence of cardiospasm.

However, during the early stage, before dilatation of the esophagus has taken place, he may detect only a slight lagging of the barium column at the cardia, in which case subsequent examinations should be made. After dilatation or sacculization of the esophagus has taken place, the x-ray findings are most characteristic and only rarely can be misinterpreted. At times, dilatation of the esophagus may be so great that it will hold 1,000 cubic centimeters of material.

Symptomatic relief usually follows dilatation of the cardia, by the hydrostatic bag advocated by Plummer, the air bag as used by Smithies, or the large olive frequently used by Vinson. Doctor Stephens' experience in having to do multiple dilatations on the majority of his patients is not in conformity with the experience of several reported series. In the use of the hydrostatic or air bag, it is most advantageous to have one assuming a dumb-bell shape when completely distended, which prevents it from slipping out of the cardiac ring as it distends. The mid-portion of the dilating bag, when distended, should be an inch in diameter, and pressure of about 25 feet of water should be used. Unless dilatation is adequate, recurrences or incomplete relief is frequent. For the occasional case unrelieved by dilatation of the cardia, celiac sympathectomy should be done.

PANCREATIC SURGERY*

By GEORGE THOMASON, M.D.
Los Angeles

DISCUSSION by Walter A. Bayley, M.D., Los Angeles; H. Clare Shepardson, M.D., San Francisco; Charles E. Phillips, M.D., Los Angeles.

GREAT interest has been revived during recent months in the matter of certain phases of pancreatic surgery. I refer especially to the condition now termed hyperinsulinism, or hypoglycemia, and to malignancy of the pancreas. It is to the consideration of these two features that this paper will be confined.

In hyperinsulinism and hypoglycemia we believe that pancreatic surgery promises to take its place as an added triumph in the successful conquest of this recently recognized surgical entity. While comparatively few cases have thus far been reported, certain features involved are being clarified and give great hopes for the future of increasingly more successful methods and technique for combating this type of pancreatic pathology.

In the light of quite recent developments, it is certainly within the range of possibility that the hitherto apparently hopeless condition of carcinoma of the pancreas may yet be brought under somewhat more successful surgical control.

EARLY STUDIES

Considering, first, hyperinsulinism and hypoglycemia: In 1920 Joslin noted spontaneous hypoglycemia in certain diabetic patients. Two years later Fletcher and Campbell outlined in detail the clinical features of an overdose of insulin; and in 1924 Seale Harris recorded his observation of this same feature in certain types of asthenic patients preceding the noon meal. To Wilder should go the greatest credit for his valuable contributions in the clarifying of this subject, in that he and his coworkers established the pathologic proof of the association between spontaneous hypoglycemia and hyperinsulinism.

WHEN SUGAR EQUILIBRIUM IS NOT MAINTAINED

Dysfunction of the pancreas with hypoinsulinism develops hyperglycemia. Dysfunction of the pancreas with hyperinsulinism develops hypoglycemia. In either case it is fundamentally a question of the maintenance of sugar equilibrium. In these cases it seems quite evident that the secretion of several glands is directly involved in the pathologic physiology. Insulin from the islands of Langerhans tends to diminish the amount of blood sugar. Secretions from the medulla of the adrenal glands, from the anterior lobe of the pituitary and from the thyroid gland, tend to increase it.

If the blood sugar falls below a critical point in consequence of a deficiency, splanchnic neurons of the sympathetic system are set in action, as indicated by increased adrenal secretion. Both the

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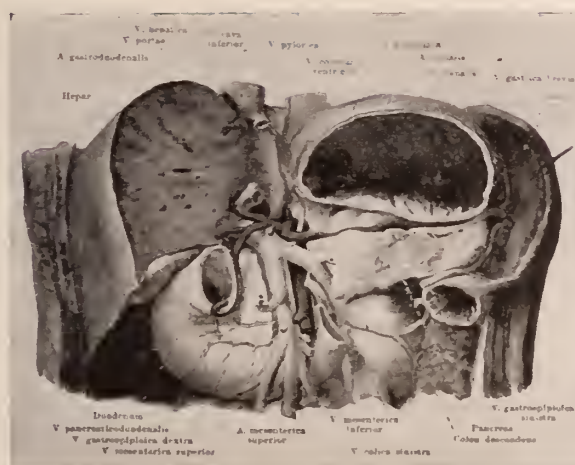


Fig. 1a.—Anatomy of region of head of the pancreas.

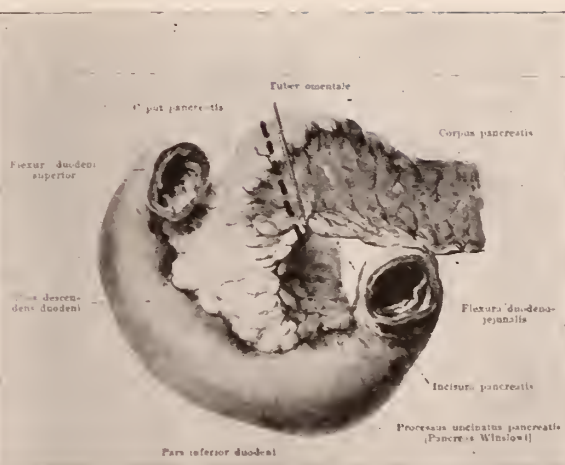


Fig. 1b.—Line of resection of the pancreas.

nerve impulses and the increased secretion of adrenalin have the effect of liberating sugar from the liver into the circulation, thus tending to restore the disturbed equilibrium. Cannon and his colleagues regard this as the first line of defense against a falling blood-sugar concentration.

HYPERINSULINISM WITH HYPOGLYCEMIA

Symptoms.—Symptoms of hyperinsulinism with hypoglycemia vary from a mere sense of weakness to attacks of unconsciousness and convulsions. It is probable that the symptoms are coincident with the lowered blood sugar, as the symptoms disappear after taking of food, especially sweets. Certain patients have developed the feature of setting an alarm clock to awaken them in the night and avoiding attacks by taking nocturnal feedings. The blood sugar may be normal between attacks. Symptoms of hypoglycemia usually begin to appear when the blood sugar is lowered to 70 milligrams per 100 cubic centimeters of blood. As a rule the lower the concentration of sugar the more alarming the symptoms become. However, in some cases the blood sugar may get as low as 40 milligrams before symptoms appear.

The most commonly observed symptoms are: A feeling of malaise, lassitude, and inability to perform even a moderate amount of physical labor. There is often trembling and sweating. There is usually a sensation of hunger which may be extreme or even agonizing. There may be mental confusion similar to that of alcoholic intoxication, and frequently a crisis resembling epileptiform seizures leading to a diagnosis of epilepsy. At times the neurologic and psychiatric aspects are so prominent that these patients are often referred primarily to a neurologist or a psychiatrist. Abdominal pain is sometimes pronounced. It may simulate appendicitis, gall-bladder infection or gastric ulcer.

PRESENCE OR ABSENCE OF ADENOMATOUS TUMORS

It is in those cases in which an adenomatous tumor has been found in the pancreas that surgery has achieved the most brilliant results in hyperinsulinism and hypoglycemia. An increasing

number of these cases are being reported in the literature. In a personal communication recently received from Professor Allen Whipple of Columbia University, New York City, he states that he has just done his seventh case in which he removed an adenoma from the pancreas. Evarts Graham of St. Louis and his colleagues report several cases, as have the surgical staff at the Mayo Clinic.

It is in those cases of hyperinsulinism and hypoglycemia where at surgery no adenoma of the pancreas is found that increasing interest centers. In the Colver Lecture on hyperinsulinism at our Medical School in Los Angeles in November, 1932, Doctor Wilder made the following statement:

"There is every reason to believe that improved surgical procedure will make it possible to obtain better results in cases of this kind. The operation is difficult technically and the surgeon probably has not removed enough of the gland. The situation is analogous to that of the early history in hyperthyroidism. The results in this new field ought to be as good as those now obtained in hyperthyroidism, and I predict that they will be."

Since Wilder made this statement at least two patients have been operated—one an infant, reported by Evarts Graham, and one an adult, a typical case of hyperinsulinism and hypoglycemia, operated by myself at the Los Angeles General Hospital, which two would seem to give some corroboration to Doctor Wilder's optimistic statement.

In every reported case in which no tumor had been found at surgery and partial pancreatectomy done, each surgeon in reporting his case stated that the disappointing results were probably due to insufficient pancreatic tissue having been removed. It certainly seems reasonable to conclude that if the capacity of the insulin factory is reduced a lessened output of the secretion must necessarily follow.

Credit for the diagnosis of the patient which came to me is due to my colleagues, Doctors Haining and Gilbert. Prior to the operation Doctor Haining noted on the patient's chart "statistically,



Fig. 2.—Operation completed.

the lesion is more liable to be a pancreatic (islet) adenoma. Probably pancreatic adenoma or pancreatic hyperplasia."

REPORT OF CASE

CASE 1.—The operation was performed September 17, 1934. There were several features of the operative technique somewhat different from any previously adopted. An upper right rectus incision was made. The gastrocolic omentum was sectionally ligated to its extreme left border. Elevation of the stomach gave excellent exposure of the pancreas. (Fig. 1a.)

Adopting the suggestion of Emile Holman, with reference to minimizing bleeding by ligating the splenic artery, we proceeded to do this—ligating the artery along the upper border of the pancreas and applying the ligature close to the head of the pancreas. The pancreas was separated a bit from below upward, sufficient to expose the splenic vein which was also ligated. The spleen was then easily removed, and the tail and body of the pancreas readily and quite bloodlessly lifted from its bed and dissected free from the posterior abdominal wall. The pancreas was held up and severed close to its head with a Percy cautery, and the proximal stump seared thoroughly with the cautery at a dull-red heat. (Fig. 1b.) A few chronic catgut sutures were taken in the stump as an extra, but possibly unnecessary measure. The gastrocolic omentum was resutured, a Penrose drain placed near the pancreatic stump, emerging through the resutured gastrocolic omentum and brought out through a stab wound in the side. There was practically no subsequent drainage and the wound promptly healed solidly. No adenoma was found in the removed specimen. (Fig. 2.)

The patient made an uninterrupted recovery. Two days postoperative the blood sugar was 138 milligrams. Five days later the blood sugar was 111 milligrams. From then until the present on an ordinary diet, even low in starch and without extra sweets, the blood sugar has ranged well within normal limits—from 87 to 91 milligrams. I have seen the patient within a month, and there has not been at any time in the twenty months intervening since the operation any return of his hypoglycemic symptoms. Preoperatively, at times his blood sugar had been as low as 40 milligrams per 100 cubic centimeters of blood.

COMMENT

As we stated in a previous paper, while one or two cases do not ordinarily prove much it seems

quite probable that with simplified technique and lessened surgical risk, subsequent experience and results will prove the subtotal pancreatectomy will give quite as much hope for this unfortunate class of patients as has been brought to those having adenomatous tumors. Further experience will also probably bring the answer to the question, "Will hyperactivity of the remaining pancreatic cells lead to exhaustion, atrophy, and degeneration?"

MALIGNANCIES OF THE PANCREAS

And now a brief discussion of the problem of malignancies of the pancreas. Surgeons have quite naturally hesitated to radically attack malignancies of the pancreas by reason of complicated anatomic features which so greatly increase the hazard of surgical intervention of this area, and, too, by reason of the very unfavorable results thus far connected with any attempt at radical surgery for malignancies in this location.

OPERATIVE PROCEDURES

Billroth, in 1884, successfully surgically removed the entire pancreas. Desjardins, in 1897, developed a type of operation for removal of the head of the pancreas, which represented an advance in surgical technique. The late Doctor Coffey of Portland did considerable experimental work in endeavoring to perfect a better technique in surgery of the head of the pancreas. Success in operations upon the body and tail of the pancreas have somewhat lessened the temerity in the matter of surgery of the pancreas.

The one particular feature which perhaps more than any other has contributed to failure of operations upon the head of the pancreas has been the apparent necessity for reintroducing into the gastro-intestinal tract the external pancreatic secretion, and which, of course, involved the connecting of the pancreas or its ducts with the bowel. As has been more recently developed by the wonderful work of Whipple and his colleagues, the preservation of the external secretion of the pancreas is apparently not imperative, and if more fully developed data proves this to be true it will remove one of the greatest obstacles to success in surgery dealing with malignancies of the head of the pancreas. In malignancies confined to the local area of the ampulla a number of successful operations have been reported, one recently a brilliant result by our colleague, Dr. Verne Hunt.

REVIEW OF THE LITERATURE

A review of the literature up to the present dealing with carcinoma in the region of the head of the pancreas shows something like eighty cases in which operation was done, and the immediate mortality was 35 per cent; 25 per cent surviving the operation and living for varying periods, but which were known to have had recurrences. It is more than likely that quite a percentage of the remaining thirty-four cases died from cancer, as the short follow-up gives no real clue to accurately determine this feature. There must have been a considerable number of unpublished cases in which the operation has been unsuccessfully attempted,

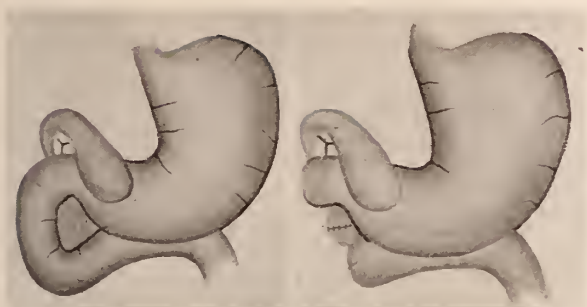


Fig. 3a

Fig. 3b

Fig. 3a.—First stage completed. Carcinoma of head of pancreas.

Fig. 3b.—Second stage completed. Head of pancreas and duodenum removed.

a recording of which would obviously make the statistical features still less favorable.

WHIPPLE OPERATION

Since it has been developed that possibly the external secretion of the pancreas is not absolutely indispensable, and with the observation that in many of these cases the pancreatic duct is already obliterated by the disease process, Whipple has developed a technique which seems to give promise of great additional value, and may possibly add, as Pfeiffer says, "a new and brilliant chapter to the surgery of this condition." The Whipple operation is of two stages:

1. A posterior gastro-enterostomy.

Ligation and section of the common duct, below the cystic duct, after determining the patency of the cystic duct, and leaving a long black silk ligature placed on the distal stem of the sectioned common duct to facilitate subsequent identification. (Fig. 3a.)

2. A cholecystgastrostomy.

Three to four weeks after the first stage the second procedure is carried out, consisting of:

(a) Ligation of the pancreaticoduodenal arteries, superior and inferior.

(b) Resection of the descending portion of the duodenum, with closure of the upper and lower ends, and a V-shaped excision of the head of the pancreas—wide of the growth, and including the ducts.

(c) Ligation of the cut end of the duct of Wirsung—and the duct of Santarini, if present—and suturing the two cut surfaces of the pancreas together tightly with silk. (Fig. 3b.)

WHIPPLE'S RESULTS

I quote from a personal letter received recently from Doctor Whipple: "I am very glad to report to you our results of the two-stage operation for removal of the duodenum, and part of the head of the pancreas, for carcinoma of the papilla. We have now carried out this operation in four cases, one having died of peritonitis, the result I think probably of the use of catgut instead of silk; a second lived for seven months and then returned with a severe biliary-tract infection and suppurative cholangitis which resulted in multiple ab-

scences and death. The autopsy showed liver abscesses and narrowing of the stump of his cholecystgastrostomy. The third case has now gone fourteen months. He also has had two more attacks of jaundice with a low-grade temperature, but has responded to cholagogues and shows no evidence at the present time of recurrence of his growth. The fourth case is one that I operated on only a month ago, so that it is too early to give much of a follow-up on him except to say that he stood the operation exceedingly well."

Doctor Whipple further states he has reports from one of the surgeons in Toronto telling him that he had performed the operation in two cases. The first one unfortunately died of pneumonia. This makes a total of six cases in which this technique has been used. The one patient living fourteen months with no external secretion escaping from his pancreas would seem a valuable contribution to the subject.

AUTHOR'S CASES

I performed this two-stage operation at the Los Angeles General Hospital on one patient, unsuccessfully, however, the man being seventy-four years of age and obviously a poor risk, but begging for relief. The second stage was done four weeks following the primary stage.

These two cases, the one in which all but the head of the pancreas was successfully resected for hyperinsulinism and hypoglycemia, and the one in which the head of the pancreas was resected, but unsuccessful so far as the life of the patient was concerned, while, of course, not giving from personal experience much data upon which to proceed, it does give considerable assurance that the mechanical difficulties of these operations are not insurmountable, and we have the courage to proceed further along these lines. Given younger patients, with early diagnosis of malignancy of the head of the pancreas, we believe this type of operation may give greater hope for better results than any previously devised.

SERIOUS FEATURES

There are, of course, formidable features which will perhaps always maintain serious hazards in this class of cases:

1. The surgeon is dealing with cancer.
2. The anatomic features involved are complicated.
3. The early symptoms are often obscure and simulate less serious conditions that lead to delay in diagnosis and the undertaking of remedial measures. Even the helpful diagnostic feature of jaundice is absent in 20 per cent of these cases.
4. The necessity of doing a cholecystgastrostomy with its potential ascending infection. Bernard has shown that at least 25 per cent of a large series of cholecystgastrostomies were followed by cholangitis. And Evarts Graham says: "The evidence with which I am familiar indicates that almost invariably the patient succumbs from multiple abscesses of the liver if the anastomosis remains patent." This is evidently what happened in one of Whipple's fatal cases.

5. Most of these patients, by reason of cholemia, liver damage, toxemia, a hemorrhagic diathesis, and asthenia are poor surgical risks, and with both stages of the operation very heavy surgical procedures, the operative mortality is certain to be high. But as against these we place the fact that these patients are well on the road to certain death, the itching of their icteric skin often intolerable, and their digestive disturbances most distressing, so much so that most of them will wish to risk the hazard of the operations. It is certain that the two-stage operation adds considerable to a more favorable prognosis, and the first stage will undoubtedly often bring much immediate relief to the patient.

IN CONCLUSION

As to the value, or lack of value, of this operation, time and experience alone will demonstrate. The combined experience of many surgeons will be necessary to properly evaluate it. And it is with the hope of stimulating renewed interest in pancreatic surgery for the conditions of hyperinsulinism and hypoglycemia, and in carcinoma of the pancreas, that this paper is presented to this Section today.

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DISCUSSION

WALTER A. BAYLEY, M. D. (1052 West Sixth Street, Los Angeles).—Doctor Thomason has given us an interesting report of his case of hyperinsulinism, or hypoglycemia, in which no adenoma of the pancreas was found. Evidently the removal of sufficient pancreatic tissue was all that was necessary to effect a cure. It has generally been thought that a tumor was present in such cases.

Although the operation becomes more formidable when a splenectomy is added, the great advantage of tying the splenic artery and vein early in the operation would seem to make this a necessity, at least in those cases where an adenoma or other tumor cannot be found and it is felt that much of the body of the pancreas must be removed.

In my first case I did not do this and, although I was able to remove over three-fourths of the body of the pancreas, the patient died of his disease fourteen months later; and autopsy disclosed a small adenoma in the posterior wall of the remaining stump of the pancreas. This tumor was only five centimeters from the duodenal border of the head of the pancreas.

In removing the head of the pancreas for carcinoma, the operator is faced with what is probably one of the most difficult operations in abdominal surgery. I doubt if many of these operations will be done, especially as most of the patients are elderly and generally in poor condition when they come to surgery. The condition has generally progressed so far that, when operation is done, about all that is feasible is an anastomosis between the gall-bladder and duodenum or stomach. This is of great advantage to the patient, and will make his remaining days much more comfortable.

However, the technique so well described by Doctor Thomason should be kept in mind, as there is always the possibility of an early case being found during the course of an exploration of the upper abdomen. The patient would then be given an opportunity for recovery from an otherwise fatal condition.

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H. CLARE SHEPARDSON, M. D. (384 Post Street, San Francisco).—Gradually the several syndromes produced by under- and overactivity of the various ductless glands is becoming recognizable. Yet the confusion which still exists concerning the morbid factors responsible for certain more or less isolated symptoms must be clarified before we can hope to apply adequate therapeutic measures. As a result, from the internist's point of view, a word of caution should be interpolated to properly appreciate this excellent paper.

No doubt the surgical technique so concisely described by Doctor Thomason is excellent, and comments concerning this portion of his discussion, for obvious reasons, should be confined to those listeners who are surgeons; yet it should be emphasized that adequate anatomical diagnosis is absolutely essential before the surgical procedure described can be undertaken. Hyperinsulinism and hypoglycemia are not synonymous terms; for while excessive activity of the pancreas resulting from either hyperplasia of the islet cells or actual tumor formation brings about a marked depression in the blood sugar, with a consequent chain of symptoms, many instances of glycopenia may result from causes entirely unrelated to alterations in the hormonopoeitic activity of the pancreas. Glucose is one of the principal sources of cellular nutrition, and elaborate hormonal and nervous regulation is provided to maintain a fairly stable concentration of this substance in the blood. Not only are several of the glands of internal secretion engaged in this regulation but, in addition, a nervous control is maintained either directly through the liver or indirectly by way of the pancreas and suprarenal glands.

The chief source of the blood sugar is the store of glycogen in the liver. Consequently any interference, either organic or functional, with the production of glycogen, the storage of glycogen or gluconeogenesis occurring in the liver, can result in the production of hypoglycemia.

Furthermore, the work of Houssay, Evans, and others, seem to indicate that only in the presence of a properly functioning adenohypophysis can normal carbohydrate metabolism proceed. As a result, certain of the functional disturbances of the anterior pituitary body are associated with glycopenia, which may be sufficiently severe to produce definite symptoms.

And it has been established, furthermore, that variations from functional normality of at least one other ductless gland, namely, the adrenal cortex and possibly, also, the medullary portion of the suprarenal bodies, sometimes are associated with profound disturbances in carbohydrate metabolism.

Finally, hypoglycemia has been demonstrated in starvation, severe and strenuous exercise, progressive muscular atrophy and in status thymicolymphaticus. In these extrainsular disturbances, where pancreatic surgery, obviously, is not indicated, dietary measures may be resorted to, often with gratifying success. Usually frequent carbohydrate feedings are suggested, but occasionally such extra consumption of glucose may actually stimulate the Langerhans islands to an even greater production of insulin, and thus defeat the object to be attained. High-fat diets avoid this complication and raise the blood sugar. Unfortunately, prolonged use of a high-fat menu is difficult in ordinary ambulatory life.

The clinical acumen of Dr. Seale Harris, in recognizing the possibility of pathologic lesions of the pancreas as being the etiologic factors responsible for the syndrome he described, has been adequately acknowledged by many investigators. And it is obvious that surgical intervention, with removal of an adequate portion of the pancreas, in those cases whose symptoms result from spontaneous hyperinsulinism, offers the chief means of therapeutically attacking this problem. It is necessary, therefore, for the surgeon to develop the technique of pancreatic surgery in the same manner that, for example, the technique of thyroid surgery has been developed. The difficulties inherent in pioneer surgery must be studied and overcome in exactly the manner undertaken by Doctor Thomason, together with such men as Whipple of New York and Holman of San Francisco, before the many disappointments can be eliminated and favorable results anticipated. Doctor Thomason should be congratulated for the timeliness of his researches, and his thesis highly commended.

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CHARLES E. PHILLIPS, M. D. (2007 Wilshire Boulevard, Los Angeles).—The author is to be highly commended for this contribution to the subject of pancreatic surgery. It is a field which has advanced with our knowledge of the physiology and pathology of the organ.

The surgical correction of hyperfunction, together with the removal of cysts and new growths affecting the pancreas, has become a reality. Only twenty-five years ago

I reported the first successful removal of a hydatid from the pancreas.

At the present time, we attack the nonmalignant tumors of the pancreas with confidence. The acute infections are diagnosed without a wide margin of error, and surgical interference seems to have resulted in a distinct improvement in results.

The clinical diagnosis of the neoplasms of the pancreas leaves much to be desired. Localized infections and inflammatory cysts may so closely simulate malignancies that radical removal of pancreatic tissue at a time where a cure for malignant tumors is possible may lead us to radical removal of relatively harmless structure, with unnecessary danger to the patient.

Four personal cases, all apparently alike, will illustrate a tumor-like mass found in the head of the pancreas presented all of the clinical aspects of malignancy, with common-duct occlusion at the ampulla. Palliative surgery was performed in all of the cases, consisting of a cholecystoduodenostomy. There were three complete recoveries, proving that the condition was benign in three of four cases. The fourth case went on to rapid termination.

Where the diagnosis is certain, radical surgical attack is justified and gives hopes for otherwise terminal condition in malignancy of the pancreas. The essayist has shown that surgical interference in cases of hyperinsulinism is clearly indicated. The pancreas offers a relatively new and most interesting field for surgical endeavor.

SURGICAL TREATMENT OF STOMACH ULCER*

By CHARLES EATON PHILLIPS, M.D.
Los Angeles

DISCUSSION by Verne C. Hunt, M.D., Los Angeles;
Asa Weston Collins, M.D., San Francisco; George
Thomason, M.D., Los Angeles.

EFFORTS directed toward the relief or cure of any disease condition should be guided by a comprehensive idea of its cause, development, possible sequelae and the factors leading to its recovery. This is particularly true concerning the relief and cure of stomach ulcers.

The question of surgical intervention depends on the prognosis following medical management on one hand, and the expected benefits and dangers of attending operative interference on the other.

PATHOGENESIS

We know no specific cause for stomach ulcers. Like those developing in other parts of the body, there are probably a number of activating factors causing the condition. In order of their importance we may enumerate:

First: Undiluted gastric juice. This will almost certainly cause ulcers, as has been shown by the experiments of Mann,¹ Dragstedt,² Ochsner,³ and others. Undiluted gastric juice may result from functional, mechanical or mental disturbances interfering with the normal working of the stomach.

Second: Infections. About 50 per cent of stomach ulcers show the presence of infectious organisms. The presence of contact ulcers in a lesser number show the relative importance of infection as an etiologic factor.

Third: General physical impairment with lack of tissue resistance predispose to their formation.

Fourth: Mechanical irritation is a minor factor responsible for some.

Fifth: Heredity and external trauma are occasional factors.

Of these causes, the presence of undiluted gastric juice is the most important. Experiments have shown that not only does undiluted gastric juice cause ulcers, but the neutralization of the acid results in their prompt relief. Of equal importance, it has been shown that the normal sequence of the gastro-intestinal tract is essential to health and function. For example, the elimination of the neutralizing action of the duodenum (by sidetracking operation) will result in frequent ulceration when the stomach contents are passed directly into the jejunum. When the stomach contents are diverted into the ileum, ulcerations almost surely follow.

DIAGNOSIS

A fairly characteristic symptomology consisting of food pain, hematemesis, melena, abdominal pain, localized tenderness, nausea and vomiting, and finally the visualization by the x-ray, in suitable cases, establishes the diagnosis of ulcer.

TREATMENT

The treatment of stomach ulcers is a medical problem except in fairly well defined limits. In early adult life the treatment is medical until such time as there is a reasonable doubt that a cure can be effected; in other words, after there have been relapses following apparent cures, and this has been repeated with the patient exercising reasonable care in diet and habits of living. It is better to consider the case surgical rather than to risk perforation, hemorrhage or long invalidism and ultimate malignancy, by further medical treatment. In later life, lowered resistance and the increased risk of malignancy shorten the legitimate time for medical treatment. Any treatment other than that necessary for operative preparation may be contraindicated.

The size, location and physical characteristics of the ulcer, together with the age and general physical condition of the patient, determine the time and character of the operation. The size of the ulcer has little significance regarding its probable malignancy. Many large ones are benign and many small ones are malignant.

Indications for Surgical Relief.—Indications for surgical relief depend on (a) the patient, his age, family history of ulcer and cancer, his adaptability to follow a medical cure; the urgency and duration of the symptoms; and the size and location of the ulcer. (b) The doctor. Indications for operation vary with the ability of the operator. One surgeon may resect a stomach ulcer with ninety-eight chances in a hundred that the patient will recover, while another operator may be able to offer the patient only fifty to seventy-five chances of recovery in the same series. The patient would be a good risk in the hands of one, while the operation would be contraindicated in the hands of another.

Surgery for relief of gastric ulcer has undergone great changes in the past decade. The opera-

* Read before the General Surgery Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

tion of gastro-enterostomy has been followed too frequently by bleeding ulcers, cancerous degeneration in remaining ulcers, dumping stomachs and jejunal ulcers. The logical treatment of ulcer is that of resection of the ulcer-bearing area, and the restoration of the normal sequence of the gastro-intestinal tract. For obvious reasons, the preservation of the duodenum, with its essential buffer substances, is desirable. When extensive pathology requires that anastomosis be performed between the stomach and the jejunum, it is essential to remove a larger part of the secreting surface of the stomach to reduce the acid content of the gastric secretion.

The results following the radical removal of the distal half of the stomach more than justify the added difficulties of operation.

A comparative table of results of gastro-enterostomy and partial gastrectomy, by Richard Lewisohn,⁴ with a follow-up over a five-year period, show that about eighteen times as many jejunal ulcers follow gastro-enterostomies as occurred in the same number of resections. These were the results found by a subsequent operation. Ulcers of the stomach requiring surgery for their relief are entitled to resection when the patient's condition will permit. By resection we include the distal half of the stomach, where over 80 per cent of the ulcers are found. The removal of this portion of the stomach not only removes the majority of the ulcer-bearing area, but also such a part of the acid-secreting surface that further ulceration is rare.

Pyloroplasty furnishes a logical restoration of the gastro-intestinal tract, permitting the normal neutralizing of the gastric juice by the mixture of the duodenal secretions and at the same time preservation of the normal sequence of the gastro-intestinal tract.

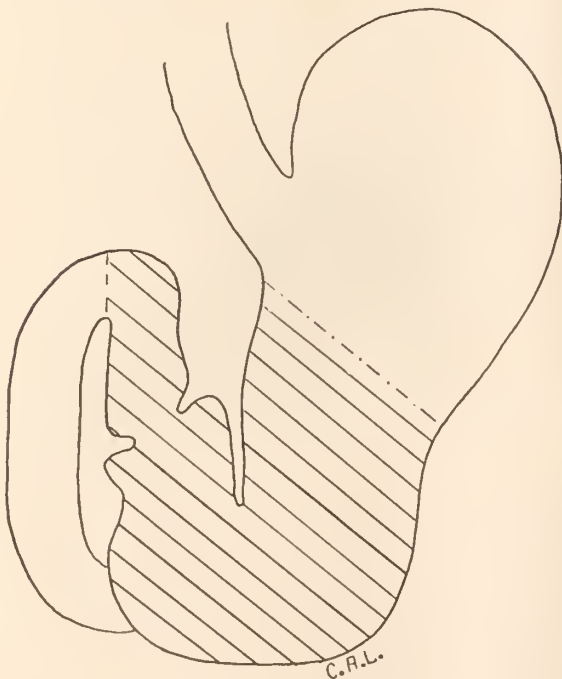


Fig. 1.—Contour of normal stomach, showing extent of gastric resection.

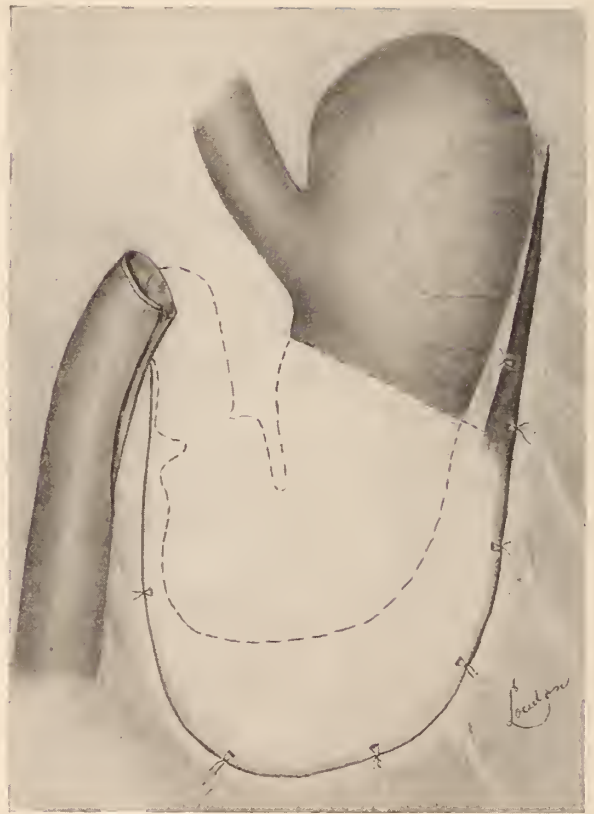


Fig. 2.—Extent of gastric resections with accommodating incisions.

Its disadvantages consist in difficulties of operative technique, but chiefly it does not remove the parts most liable to suffer subsequent pathologic changes. The development of ulcer surgery has been toward the wider removal of the ulcer-bearing area, and the attaching of the open end of the stomach to the side of the duodenum. The author's technique has been similar to that described by Horsley⁵ for the relief of cancer of the stomach.

PROCEDURE IN OPERATION

After preliminary preparation, a Levine tube is passed into the stomach through the nose before the anesthetic is started. Adequate exposure is afforded by a paramedian incision extending from the ensiform to the right of the umbilicus. The lesser peritoneum is explored by the finger through the gastrohepatic omentum. The extent of the pathology and the mobility of the stomach are determined. The gastrocolic omentum is opened, and Pahr clamps are applied across the stomach, which is severed between them by the cautery. The distal part of the stomach is turned to the right and the pylorus is freed to the first portion of the duodenum. A small Pahr clamp is placed just beyond the pylorus. The pyloric artery is tied. A crushing clamp is not applied to the duodenum, but the blood supply is controlled by the left thumb and finger until the bleeding points are picked up individually and tied. A clamp devitalizes the tissue to be approximated and may result in an insecure hemostasis.

The second portion of the duodenum is mobilized by incising the reflection of the peritoneum to the right. The duodenum is then rolled over on its mesentery, so that it approximates the stump of the stomach which is mobilized by incising the gastrocolic omentum. The anterior side of the duodenum is split down its long axis for about two inches, so that the open end and side of the duodenum will approximate the cut end of the stomach. The posterior side of the cut end of the stomach is fixed to the superior border of the duodenum, while the greater curvature of the stomach is fixed to the bottom of the incision made in the second portion of the duodenum. The serous and muscular coats of the stomach are attached to the corresponding layers of the duodenum by a continuous suture of chromic gut. The mucosa is then approximated by a running stitch of the gastro-intestinal suture, accurately approximating the mucosa of the stomach to that of the duodenum. The Levine tube, which was passed into the stomach before the anesthetic was started, is now adjusted in the stomach or passed into the duodenum if desired. The anterior row of sutures completes the anastomosis. This is further reinforced by another row of mattress sutures of silk or linen. The closure of the abdominal wall should be secure and adequate, as tissue repair may be slow in those suffering from malnutrition. Preference is for a forty-day chromic stitch for closure of the fascia.

With very extensive pathology the operation of a subtotal gastrectomy may be indicated. The so-called Polya method of closure may be the method of choice in effecting the restoration. The duodenum is closed by infolding and suturing to the pancreas. The anastomosis is completed by an end-to-side closure, the stomach to the jejunum. Theoretically as well as practically, it is desirable to resect much of the acid-secreting surface of the stomach before the anastomosis is completed with the jejunum. It is only by this mechanical lowering of the acidity of the stomach that the jejunum is able to stand the direct action of the gastric juice.

COMPLICATIONS

Hemorrhage.—Hemorrhage occurs in 8 per cent of stomach ulcers, and is responsible for a mortality of 16 to 29 per cent of those affected (Finney⁶). Hemorrhage becomes a surgical problem when a known localized ulcer continues to bleed after adequate medical treatment has been administered. It becomes a surgical problem while the patient is still able to stand operation. Competent operative interference will reduce the mortality rate from one-half to one-fourth of the prevailing rate, attending the so-called conservative treatment. Surgical intervention should consist of attack on the bleeding point. Excision of the ulcer, hemostasis and careful closure of the mucosa in the least possible time consistent with good work is essential. Hemorrhage from an unlocalized lesion is not surgical.

Perforation.—Perforation occurs in over 25 per cent of ulcers, and accounts for 7 per cent of the deaths (Finney⁶). The treatment of perforation is immediate operation. The mortality in-

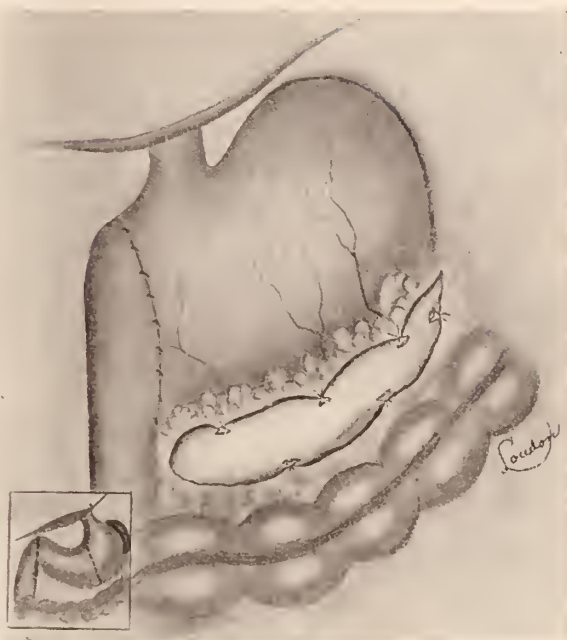


Fig. 3.—Gastro-duodenal anastomosis completed.

creases with each hour of delay. Perforated ulcer treated surgically within the twelve hours shows a mortality of about 10 per cent. When the operation is delayed the second twelve hours, the mortality becomes double or more. After twenty-four hours' time has elapsed nine out of each ten have lost their chance of recovery. The administration of opiates before a positive diagnosis has been made is usually responsible for the delay in operation.

Where there is a history of preëxisting ulcer, and the patient is seized with sudden pain, shock, abdominal rigidity along with typical blood changes, the diagnosis is easy. In atypical cases, without ulcer history and with comparatively mild symptoms, the condition may be overlooked. The administration of morphin before diagnosis is made becomes the patient's death warrant. X-ray evidence of air in the subphrenic space becomes a positive symptom when found, but its absence should not even delay operation when the other symptoms of perforation are positive. Operation consists of closure of the perforation and drainage. Excision of the ulcer may facilitate closure; a longitudinal incision and a transverse closure when the perforation is near the pylorus relieves obstruction. Closure of the perforation should be followed by a removal of the extruded stomach contents. Drainage should be inserted to the bottom of the pelvis and brought out through a suprapubic stab wound. Accumulations to the outer side of the cecum should be removed and drained by a separate stab wound made to the mesial side of the iliac spine when necessary.

Ulcus Carcinomatosus.—Signs of malignant changes call for a wide resection of the ulcer together with a removal of all tributary glands. Attachments to the pancreas are removed by the cautery, and drainage is inserted to the damaged pancreatic tissue. Restoration of the gastro-intestinal tract depends on the amount of tissue

removed. The end of the stomach to the side of the duodenum is the method of choice. Where these structures cannot be approximated, the restoration may be effected by the so-called Polya or by a Bilroth II. With multiple ulcers near the cardia, a complete gastrectomy is indicated where there is a fair chance of success. Gastro-enterostomy is used only as a palliative operation.

Many apparently hopeless cases have passed the two-, three- and five-year periods without recurrences. The patient should be given an opportunity to recover by radical surgery even though the chances seem to be small.

IN CONCLUSION

Removal of persistent pathology and restoration of the normal sequence of the gastro-intestinal tract is the aim of surgery. Surgical relief of ulcer should not be undertaken by the casual operator. The mortality rate follows too closely the ability of the surgeon to permit of uncertainty. The average surgeon will not attempt the removal of a cataract, yet failure would result only in the loss of an eye. Lack of skill or of judgment in stomach surgery results in the patient's death. The field of stomach surgery has great possibilities. Regard for the lives of patients and for the reputation of the profession demand care and efficiency in this work.

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DISCUSSION

VERNE C. HUNT, M. D. (727 West Seventh Street, Los Angeles).—It is well known that malignant degeneration of a duodenal ulcer practically never occurs, and that primary malignancy at the site of a previously existing duodenal ulcer seldom, if ever, occurs; and, furthermore, that excision of a duodenal ulcer is not necessary in the course of a surgical procedure to produce a satisfactory result, in terms of permanent relief of all symptoms. Because a small percentage of chronic gastric ulcers undergo malignant degeneration, and because in a larger percentage of cases it is difficult and often impossible clinically to differentiate a benign gastric ulcer from an early primary carcinoma, or from a carcinomatous ulcer of the stomach, it is essential, in the surgical treatment of a gastric lesion, to excise the lesion as part of the surgical procedure. Little difference of opinion exists regarding this principle. Excision of most gastric ulcers may be accomplished by either relatively conservative methods or by radical partial gastrectomy. Not all gastric ulcers are amenable to surgical excision. In a recent review of 131 cases of gastric ulcer that I have operated upon, it was found that in 14 per cent of the cases the lesion was situ-

ated in the relatively inaccessible cardiac third of the stomach, either on the posterior wall or at the lesser curvature; in which instances excision was not readily instituted. There were others in which their high situation, or where protective perforation of a large ulcer posteriorly made excision inadvisable. In 20 per cent of the cases of gastric ulcer, excision of the lesion, for one reason or another, was not carried out, but instead the indirect operation of posterior gastro-enterostomy was employed. In the remainder of the cases the relatively conservative surgical procedure of local excision of the ulcer and posterior gastro-enterostomy was employed in 71 per cent of the cases, and partial gastrectomy in 29 per cent of the cases. The selection of the surgical procedure best suited to the individual case is based largely on the size and location of the lesion. Experience has adequately proved that the operation of local excision of a small benign gastric ulcer in the pyloric or middle third of the stomach and posterior gastro-enterostomy has been productive of excellent results, with few recurrences of a gastric ulcer and few instances of recurrent ulcer at or about the gastro-enterostomy stoma. In the cases of large gastric ulcer in an accessible portion of the stomach, and particularly such lesions in which, upon inspection and palpation, it is impossible to dismiss the question of a malignant lesion and in which gastric resection may be carried out, partial gastrectomy is the operation of choice. The method of establishing gastro-intestinal continuity following partial gastrectomy, whether by the Billroth No. 1 procedure, the gastrojejunal end-to-side method of Polya, or the gastroduodenal end-to-side anastomosis as described by Doctor Phillips, is dependent upon many factors, and the surgeon will usually select the method best suited in his hands to the situation as he finds it. There is much on a physiologic basis to urge the utilization of end-to-side gastroduodenal anastomosis, as described by Doctor Phillips as the method of choice in restoring gastro-intestinal continuity after partial gastrectomy when it may be accomplished readily. It is noteworthy, however, that sufficient mobilization of the duodenum is not always readily accomplished to facilitate such an anastomosis with maximum assurance of satisfactory post-operative function. Doctor Phillips has brought to your attention a method of establishing gastro-intestinal continuity after partial gastrectomy, which is applicable in certain cases, and physiologically fulfills certain prerequisites to the elimination of new anastomotic ulcers, which are not fulfilled entirely by the usual methods of reestablishing gastro-intestinal continuity.

I should like to ask the question, "What has been the mortality rate of this particular procedure in the surgical treatment of gastric ulcer?" While the operation of partial gastrectomy is the operation of choice or necessity in certain gastric ulcers, the relatively low mortality rate and the excellent results of the conservative surgical procedure of local excision of a gastric ulcer and posterior gastro-enterostomy should not be forgotten.

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ASA WESTON COLLINS, M. D. (450 Sutter Street, San Francisco).—My experience in partial removal of the stomach and gastro-enterostomy consists of over 200 cases, practically all directed toward the relief of pyloric and duodenal ulcer.

In an article published in *CALIFORNIA AND WESTERN MEDICINE* in September, 1931, I reported ninety-four cases, with a mortality of 5.25 per cent. All of these cases were operated by a method of my own, which is a modification of the Doyen operation. There are four points to be observed in all operations: No leakage, no hemorrhage, rapid technique, and no tension of any of the structures. There are two chief functions of the gastro-intestinal tract: First, digestion and second, motility. If anything interferes with the free movement of peristalsis, trouble starts.

Faulty technique is the cause of failure in practically all operations in this field. If the technique is perfect, all should survive. Shock is overcome by rapidity of operating, and the manual dexterity of the operator insures against hemorrhage and leakage. Plastic work on the stomach or intestine is meticulous, and I quite agree with Doctor Phillips that this type of surgery should be con-

fined to a few well-qualified surgeons. I do not believe that there is any one standardized operation to be used in all cases. Silk and linen are nice to work with, but I never use them.

The point that Doctor Phillips wants to put over, as I take it, is the removal of as much of the pyloric end of the stomach as possible, to prevent postoperative jejunal ulcer from the acid of the stomach. This he has done very nicely, and I quite agree with him.



GEORGE THOMASON, M. D. (606 South Hill Street, Los Angeles).—Perusal of Doctor Phillips' paper discloses much for approval and very little ground for difference of opinion.

Certain features of the paper will bear repetition, merely by way of emphasis; as, for instance, that the treatment of stomach ulcer in early life is certainly medical, as such a large majority of them have so strong a tendency to spontaneous healing if given a fair opportunity by means of a carefully regulated regimen, intelligently and faithfully carried out by the patient.

In harmony with the sentiments of the paper we cannot justify the all too radical procedure of extensive gastric resection for ulcer in younger patients, as so generally practiced by Continental surgeons, and by a few in this country as a routine practice. The simple procedure of excision of the ulcer and a pyloroplasty will be feasible in a majority of these cases, and the pyloroplasty will sufficiently modify the gastric function and secretion as to make any recurrence of the ulcer but a remote possibility.

Boldyreff of Battle Creek, Michigan, was evidently correct in his contention that the level of gastric acidity under normal circumstances is regulated by the neutralizing effect of the pancreatic juice, which gains access to the stomach by reflux through the pylorus. This feature was later confirmed by the researches of Olch and Elman. A pyloroplasty, by removing sphincteric action of the pylorus, certainly greatly facilitates this reflux of alkaline juices, thus lowering gastric acidity.

While most of the resections of the stomach do not actually remove the acid-producing glands—these being largely located in the cardia—the resection does take away the area in which the reflex stimulation of the peptic glands originates, and produces, according to Lewisohn, at least a hypochlorhydria in more than 80 per cent of cases. In cases in which conditions are present, so as to make pyloroplasty impractical, certainly resection should be done in preference to an excision of the ulcer and gastro-enterostomy. In older patients, because of the increased danger of malignancy complicating the ulcer, and in younger individuals where less heroic measures cannot safely be utilized, resection is obviously the procedure of choice.

Doctor Phillips states: "The indications for operation vary with the ability of the operator." While this unfortunately is true, it is to be deplored, and the ideal procedure could be carried out if only experienced and wholly qualified surgeons would undertake this testing type of surgery.

The type of operation which Doctor Phillips outlines, the modified Billroth No. 1, by preserving the continuity of the normal gastro-intestinal tract in reestablishing the connection between the stomach and duodenum, is undoubtedly the most desirable when possible to perform. It is surprising at times the amount of stomach which can be removed and still have the cut edge of the stomach brought over to the duodenum. When this is done, we believe it is desirable to tack the stomach to the round ligament of the liver with a few interrupted sutures, which will greatly relieve the tension upon the suture line.



DOCTOR PHILLIPS (Closing).—Doctor Hunt has included duodenal ulcer in the scope of this discussion of the treatment of stomach ulcer. I believe it really belongs there. Granted, duodenal ulcer rarely, if ever, becomes malignant; yet the fact that it frequently does not heal, bleeds and sometimes perforates, following surgery which does not remove it, is sufficient reason for its removal when it can be performed without undue risk to the patient.

In operating on gastrojejunal ulcers, I have found the duodenal ulcers still active in several cases. The longest period of activity of a duodenal ulcer, following a gastro-enterostomy, noted in my work, was one of over fifteen years with serious exsanguination occurring several times during that period. These findings have convinced me of the necessity of removing ulcers of the duodenum, consistent with the safety of the patient. We have also encountered perforations of duodenal ulcers following functioning gastro-enterostomies.

Doctor Hunt has pointed out the impossibility, in all cases, of clinically determining the malignancy of stomach ulceration. Safety demands the wide excision of all ulcers and the adjacent glands such as can only be accomplished by gastric resection.

The operation I have described permits the wide removal, with comparative ease, of the distal half of the stomach, the adjacent glands, and first portion of the duodenum. Ulcers of the fundus of the stomach show such a high percentage of malignancy as to require their radical removal routinely.

I have found that about 80 per cent of the cases of stomach ulcers can be readily removed by the resection and duodenal anastomosis described. The remainder should be resected, and the continuity of the gastro-intestinal tract be restored by the methods of Polya or Billroth, or by total gastrectomy. Local excision is not sufficient where malignancy may exist.

There has been no mortality in uncomplicated cases since I have adopted this method. There has been no untoward results in these few cases (twenty). Convalescence has been shorter, and the gain in weight and strength has been much more rapid than in any other type of stomach operation. The results have been much superior to others in a previous series of two hundred cases of stomach ulcer treated by gastro-enterostomy and pyloroplasty.

The mobilization of the duodenum need not be carried on to any great extent. In cases of ulcer of the first portion of the duodenum, a moderate displacement of the duodenum is met with a wide displacement of the stomach to the right.

In the removal of gastrojejunal ulcers, following gastro-enterostomy, where the enterostomy was placed well to the left, it was necessary to resect not only the enterostomy opening but also the duodenal ulcers, which were still active. The results were a fundus lying in the midline, and the line of anastomosis was to the right. The results in these cases were the same: the patients noticed hunger a little sooner, and the added food caused a little more rapid gain in weight. Comparing the results of gastro-enterostomy, pyloroplasty and resection, I am convinced that in suitable cases resection offers the greatest chance for complete recovery.

The dangers of resection in competent hands are not larger than in gastro-enterostomy or pyloroplasty. Doctor Collins made a statement which I wish to emphasize: "Faulty technique is the cause of failure in practically all operations in this field." I would substitute "mortality" for "failure." The aim of the operation is not only to prevent jejunal ulceration from lowering the acidity of the stomach, but, more important, it furnishes an opportunity to remove a large majority of the ulcers and ulcer-bearing area in the stomach, and at the same time reestablish the continuity of the gastro-intestinal tract so that subsequent ulceration will be almost unknown.

Doctor Thomason has brought up the question of reduction of the acidity of the stomach following the removal of the pyloric sphincter by the influx of the duodenal secretions into the stomach.

Dr. Emmet Rixford brought out the theory of gastric secretion, that our progenitors gulped large chunks of food, which were unable to pass the pylorus. Nature remedied this by an outpouring of additional gastric secretion digesting the pieces so they could pass the pyloric sphincter. This inheritance possibly explains the hypersecretions in duodenal contraction. Hyperacidity depends on the reflex set up by the presence of food trying to pass the pylorus. Section of the pyloric end of the stomach destroys the reflex arc responsible for the excess acid secretion. The radical reduction of acidity removes the chief cause of

ulceration, and removing the part of the stomach most liable to ulceration reduces the incidence of ulcer to a minimum.

In conclusion, I wish to emphasize that the field of stomach surgery should be restricted to those adept and thoroughly trained. The average doctor may not attempt many operations where there is little danger to the patient's life, but he will sometimes attempt to remove stomach ulcers when lack of efficiency means death to the patient. Lack of skill is responsible for 90 per cent of the accidents of gastric surgery.

I deeply appreciate the discussion of Doctors Hunt, Collins, Rixford, and Thomason; they have added much to this brief presentation.

OSTEOMYELITIS AND SUPPURATIVE JOINTS: SALT WATER POOL TREATMENT*

By A. BROCKWAY, M.D.
Los Angeles

DISCUSSION by Francis M. McKeever, M.D., Los Angeles; Frederic C. Bost, M.D., San Francisco; Samuel S. Mathews, M.D., Los Angeles.

THESE two conditions, osteomyelitis and suppurative arthritis, are presented together as one subject because they are closely allied clinically, and are also often associated together as part of the same infection process. However, from the standpoint of treatment, they should be considered as separate clinical entities because, as will be shown later, the fundamental principles underlying their treatment are distinctly different.

Most of the various antiseptic formulae that have been developed have been tried in the treatment of osteomyelitis, but the ideal antiseptic that will destroy bacteria in the living body without harming the tissues has not been found. In osteomyelitis, particularly, such form of treatment is futile, because the solution cannot possibly reach the microscopic limits of the infection.

With the advent of bacteriophage treatment, the medical profession had high hopes that here at last was a form of therapy that would have a direct and beneficial therapeutic effect in osteomyelitis. From a theoretical standpoint this would seem the ideal way to deal with any type of infection; but, in spite of all the theoretical implications, the fact remains that the stubborn course of bone infection has not been greatly altered.

I think the same may be said of maggot therapy. There is no doubt that good results have been obtained with this mode of treatment, and the same may be said of other forms of treatment in use. Many cases of osteomyelitis, either because of the low virulence of the organism or the high resistance of the host, tend to be a self-limiting disease and eventually get well. However, acute bone infections remain one of the most intractable conditions that the surgeon is called upon to treat.

The fundamental principles underlying the treatment of infection have been known and practiced for a long time. These two cardinal principles—adequate drainage and rest—are as true and impor-

*From the clinics of the Orthopedic Hospital, Los Angeles.

Read before the Industrial Medicine and Surgery Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

TABLE 1.—*Acute Suppurative Arthritis*

Eight Cases Incision and Drainage Followed by Salt Pool Treatment		
Joint involved	{ Knee 5 cases Hip 2 cases Ankle 1 case	
Sex	{ Male 6 Female 2	
Average age	6½ years	
Invading organism ...	{ Negative culture 2 Streptococcus 4 Staphylococcus aureus 2	
Time required for wound to heal	2.8 months	
Return of motion	Complete	
Time required to obtain motion	5 months	

tant today as they were in the earliest days of surgery.

The practical application of these principles in the treatment of osteomyelitis is best exemplified in the Winnett Orr treatment. When meticulously carried out, this method not only satisfies the two prime tenets of adequate drainage and rest, both local to the diseased part and general rest of the patient, but it also prevents contamination from frequent dressings. I think it may be said without much fear of contradiction that the Orr treatment has given on the whole to surgeons over the country a degree of success that has not been approached by any other form of treatment.

In spite of the above statement, I believe that this treatment has definite shortcomings in certain types of cases. When the infective process is in close proximity to the major joints, especially when located at the distal end of the femur or near the elbow joint, and more particularly if there is an accompanying suppurative arthritis of the neighboring joint, then one of our main problems in treating this patient is to preserve for him as much joint motion as possible. Restoration of motion in a pus-ridden joint is not best accomplished by a long period of immobilization in plaster casts.

It is in support of this contention that the salt water pool treatment of bone and joint infections is here described. While we have used this treatment in over a hundred cases of osteomyelitis, this paper is concerned only with suppurative arthritis and osteomyelitis in which adjacent joints are also involved, or when the diseased process closely encroaches upon joint structures. It is in these particular types of cases, in which preservation of joint motion is one of the vital issues, that the salt-pool treatment has its greatest field of usefulness.

ACUTE SUPPURATIVE ARTHRITIS

It was first shown by Willems during the World War, and it has been thoroughly substantiated since, that regeneration of pus-ridden joints and restoration of function are best accomplished by early evacuation and motion.

Motion of an infected joint should not create muscle spasm. It should be painless and free of the fear of pain, and there should be no discomfort

in the joint after the patient returns to bed. The use of the salt pool satisfies all these requirements, and these requirements are especially important when treating children. Motion in the water mechanically cleans away the infection, and because the water is hypertonic, there exists an osmotic pressure between this fluid and the body fluids, so that drainage is encouraged and accelerated from the innermost depths of the wound.

The salt concentration of the water in the pool is between 6 and 7 per cent, approximately the same strength as sea water. At this concentration the water sterilizes itself and cultures have always been negative. The temperature of the pool is maintained at about 96 degrees and the treatment lasts about thirty minutes. The floor of the pool should be sloping so that weight bearing on an infected joint can be gradually increased. As you know, the weight of the body standing in water is the weight of the body above the water line.

In this series there were eight cases of suppurative arthritis without bone involvement. In five the infection was in the knee, two in the hip, and one in the ankle. The average time required for healing was two and eight-tenths months, and complete motion was restored in every case in an average of five months.

In these cases the joint is incised widely and irrigated with several gallons of warm normal saline solution. The part is splinted for two or three days, and then the patient is put in the salt pool daily.

From these cases, and from the reports of other surgeons, it seems definitely established that acute joint infections, especially in children, respond well to early drainage and motion. By all odds, the best and most painless way to carry out this motion is by means of the salt pool.

ACUTE OSTEOMYELITIS WITH SUPPURATION OF THE ADJACENT JOINT

We will now consider those cases of osteomyelitis involving the ends of long bones, and in which there is an accompanying suppurative arthritis.

With this type of case it has been our routine to do a wide saucerization of the bone, removing

TABLE 3.—Acute Osteomyelitis in Close Proximity to Joints	
Ten Cases	
Bone involved (close approximation to joint)	{ Distal end of femur.... 5 cases Neck of femur..... 1 case Proximal end of tibia.. 1 case Distal end tibia..... 1 case Entire humerus..... 1 case Entire radius..... 1 case
Sex	{ Male 8 Female 2
Average age	12.7 years
Invading organism....	{ Staphylococcus aureus.. 7 cases Staphylococcus albus ... 1 case Streptococcus 1 case Not recorded 1 case
Average time wound drained.....	7.5 months
Return of motion.....	{ 7 joints.....Complete 6 joints.....One-half normal

as much of the diseased bone as possible, and pack the wound lightly with vaseline gauze as in the Orr treatment. The joint is also opened and irrigated. A plaster cast or spica is applied, depending on the bone involved.

The cast is removed in four to six weeks, which is about the time the first change of cast is made in the Orr treatment. A splint is applied and daily pool treatment started.

While motion at this early stage would seem a violation of the principle of rest, still the motion permitted in the pool is not such a violation of this tenet, as might be presumed. The buoyancy of the salt water, removing the gravity load, permits motion without pain or muscle spasm, and the part is splinted between treatments or even during treatment within the first week or so. Almost without exception the patient will state that the extremity feels better after his pool treatment.

There is another advantage of this form of treatment, especially in older patients. Remaining idle in bed for months in an ill-smelling cast does not appeal to some patients, particularly the more fastidious. In the pool the patient can daily watch the improvement of motion in the stiff joints and can see the wounds become smaller and cleaner. Certainly, a psychic appeal that is more than imaginary.

In this series there were twelve cases in which there was an osteomyelitis with suppuration of the adjoining joint. The return of motion in such cases, naturally, is not as great as in those in which there is no bone involvement.

The hip and ankle show more tendency to heal with motion while the knee and elbow have greater tendency to heal with ankylosis.

In the six hip cases, there was complete return of motion in two, and ankylosis in one; and in the remaining three the end-result was motion, varying from one-half to two-thirds normal.

In the three knee cases, one had a return of motion two-thirds of normal, and the other two ended in complete bony ankylosis; but it is only fair to state that one of these patients came to surgery late, and after there was considerable joint

TABLE 2.—Acute Osteomyelitis with Suppurative Arthritis	
Twelve Cases	
Joint involved (and adjacent bone)..	{ Hip 6 cases Knee 3 cases Ankle 2 cases Elbow 1 case
Sex	{ Male 9 Female 3
Average age	10.5 years
Invading organism....	{ Staphylococcus aureus.. 7 cases Staphylococcus albus ... 1 case Streptococcus 2 cases Not recorded 2 cases
Average time wounds drained	16 months
Return of motion {	3 cases—complete 5 cases—averaged one-half normal 4 cases—ankylosis

dissolution and bone destruction in both the lower end of the femur and the upper end of the tibia. In such cases, experience has shown that joint motion is doomed, and it is better to proceed with the Orr treatment rather than attempting to gain motion.

There were two ankle cases. In one there was complete return of motion, and in the other the range of motion was one-third normal.

One elbow case resulted in complete fusion.

In those cases in which there is an osteomyelitis of the head and neck of the femur with a purulent empyema of the hip joint, the leg is immobilized for several months in plaster before pool treatment is started. In these hips the head of the femur usually becomes a sequestrum which requires surgical removal. Maintaining the remains of the neck in the acetabulum is the problem of first consideration. Adequate motion will develop later; and if one is successful in preventing the neck dislocating upward, a good stable hip will result that will stand up under ordinary use, and usually with motion of at least half-normal range.

OSTEOMYELITIS IN WHICH THE DISEASE PROCESS CLOSELY ENCLOSES UPON JOINT STRUCTURE

We come now to the third type of case in which the salt pool treatment is especially useful. These are the cases in which the osteomyelitic process, while not involving the joint proper, yet lies in very close approximation to the joint, involving at times the epiphyseal plate.

Some joints, like the elbow, but particularly the knee, tend to heal with considerable restriction of motion if they are long immobilized. Drainage for months about the knee, especially from the distal end of the femur, causes a plastering down of the vasti and rectus femoris muscles to the femur, and with this there occurs a thickening and shortening of the capsule of the knee, a condition which is aggravated by immobilization and minimized by early motion.

In this series there was an osteomyelitis near the ends of ten of the long bones, the diseased process being in close approximation to thirteen joints.

Since the joint itself was not involved, naturally, a greater return of motion could be expected than in the series described just above.

Of the thirteen joints, there was complete return of motion in seven, and in the other six the residual motion averaged about one-half normal.

I do not wish to give the impression that the salt pool has solved the problem of the treatment of osteomyelitis and suppurative joints, but I am convinced that in the selected type of cases as above described, it will give an end-result that cannot be duplicated by other methods.

SUMMARY

1. Thirty cases of acute suppurative arthritis and osteomyelitis with joint involvement, treated by surgical drainage followed by early motion in the salt-water pool, are presented.

2. In the eight acute suppurative arthritis cases without bone involvement, there was complete return of motion in all cases in an average of five months' time.

3. In the twenty-two cases of osteomyelitis with concurrent purulent infection of the neighboring joint and osteomyelitis closely encroaching upon joint structure, there was a gratifying return of joint motion in most instances.

4. The salt-pool treatment permits early motion without muscle spasm, pain or the fear of pain, and thus does not violate the principle of rest that is so essential in the treatment of any infection.

5. Motion of joints in the salt water not only mechanically washes away the pus, but, because it is a hypertonic solution, there is an osmosis outward of the tissue fluids which causes a thorough cleansing of the wound from its innermost depths.

3523 West Twelfth Street.

DISCUSSION

FRANCIS M. MCKEEVER, M. D. (1136 West Sixth Street, Los Angeles).—Doctor Brockway's statistics are very impressive. Particularly striking are his results with those patients in whom a primary osteomyelitis has ruptured into a joint.

The acute suppurative arthritis in which only synovial membrane is infected, with timely adequate drainage as a rule recovers sufficient motion so that no marked permanent disability results. The joint infected by the extension of an osteomyelitis through its articular cartilage is a much more discouraging situation which, altogether too often culminates in a complete ankylosis or a few degrees of painful, useless motion after a long exhaustive illness.

Doctor Brockway has mentioned adequate drainage of both the infected bone focus and of the joint. He has stressed early mobilization in a hypertonic saline medium.

The percentage of recovery of motion which he has mentioned is indeed excellent, and certainly warrants consideration of the saline pool as a valuable adjunct in the postoperative treatment of this type of case.

I feel, however, that a little more emphasis should be laid on the early diagnosis of the extension of the infection into the joint cavity, and the timely dual drainage of both the infected bone and the invaded joint, if articular cartilage is to be saved from the ravages of the products of inflammation.



FREDERIC C. BOST, M. D. (384 Post Street, San Francisco).—Doctor Brockway's paper is of real value. He has demonstrated by his splendid results the efficacy of hypertonic saline baths. No group of cases cause us more concern than those with which Doctor Brockway's paper has dealt, and any method of treatment that offers such hopeful progress is most welcome to all of us.

The physiologic basis for hypertonic saline baths to me seems a most logical one. The end-results, here presented, give clinical proof to this point. The physical side of this treatment might at first seem to make it impractical to most of us. However, all that is necessary is a bathtub, warm water and a sack of salt, and certainly we can all provide such accessories.

Since learning of Doctor Brockway's work, I have had the opportunity to use the salt-water treatment in several cases, and I can attest to the validity of his statements concerning the improvement in general condition, the relief from pain, and the marked enthusiasm on the part of the patient so treated. The rapidity with which dirty, sluggish wounds take on new life and cleanliness is remarkable. Limited use of this form of therapy will, I believe, serve to convince most of us that there is no better method for treating a septic joint.

We have all seen osteomyelitis, either with or without joint involvement, progress favorably for a limited period of time only to reach a stage of extreme sluggishness, which usually bespeaks a long and discouraging period of

chronicity. Doctor Brockway's method of handling these cases by the use of stimulating saline baths is to me a most excellent one.

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SAMUEL S. MATHEW, M.D. (1913 Wilshire Medical Building, Los Angeles).—Doctor Brockway's results in the treatment of suppurative arthritis without bone involvement, by means of salt water pool treatment, are indeed gratifying. Just what part the pool treatment itself played in these excellent results is, however, hard to estimate. It has been my feeling that the prognosis for return of motion in an involved joint depends, to a great extent, on the organism present and what destruction has already taken place in reference to the articular cartilage. We often see, particularly in children, those cases in which the knee is swollen, with moderate amount of local heat, and associated with but little constitutional reaction. On incising such joints and thoroughly washing them out with large quantities of normal warm saline solution, the prognosis is good for full return of motion, the motion itself being started as the local symptoms subside. Then there are such cases where the invading organism is far more destructive and there has been a greater change in the joint, primarily due to delayed drainage. Our prognosis here is poor for return of normal function, regardless of our after-care. I have always felt that in either case active motion should not be started until local symptoms have subsided, because we are dealing with a diseased joint which should be kept at rest during its acute stage. Doctor Brockway has suggested an easy method of starting early motion by pool treatment, but he has emphasized that such early motion should be done without causing muscle spasm or pain. What importance we can place upon the use of salt water in such pool treatment I cannot state, because I feel that motion should not be started until, as I have said, the disease process has quieted down sufficiently.

CAN THE STATE EXAMINE PEOPLE ENTERING THE STATE WHO MAY BE SUSPECTED OF HAVING AN INFECTIOUS DISEASE?

OPINION OF THE ATTORNEY-GENERAL OF CALIFORNIA: IN RESPONSE TO REQUEST FROM
STATE BOARD OF HEALTH

In the January issue of CALIFORNIA AND WESTERN MEDICINE, editorial comment was made on "Indigent Camps in California: A New and Pressing Problem." (See page 2 of January CALIFORNIA AND WESTERN MEDICINE and also comment in this number, on page 146.)

The opinion rendered by Attorney-General U. S. Webb and Deputy Attorney-General Leon French contains much general and specific information of interest to members of the medical profession, and is, therefore, printed in full.

STATE OF CALIFORNIA
LEGAL DEPARTMENT

San Francisco, February 10, 1937.

Honorable Walter M. Dickie
Director, Department of Public Health
San Francisco, California

Dear Sir:

I have before me your communication under date of October 27, 1936, which is as follows:

It has been estimated that during the last two years somewhere in the neighborhood of 200,000 itinerant people have moved into California from the middle-western states and are now located in itinerant camps and government resettlement camps in the State of California. Many of these people are suffering from infectious diseases, namely, tuberculosis, trachoma, dysentery, typhoid fever, etc., all of which are a menace to the people of the State of California, for the reason that these migratory people are not entitled to institutional nor medical care

in the counties in which they are located, because of lack of residence.

In order that this condition may not be continued indefinitely, I would respectfully request the following opinion: Does the State Department of Public Health have the right under the law to examine people entering the State who may be suspected of having an infectious disease? If they have not sufficient funds to provide proper institutional or hospital care, can they be denied permission to enter the State?

There is on the statutes, as you know, "an Act to prevent introduction of contagious diseases into the State," approved March 15, 1883, but this refers only to train service, I believe.

As the questions which you submit are of major importance not only to the people of the State of California but also to the individuals coming to the State of California from other states, such questions have been given very careful and detailed consideration, particularly in view of the fact that, so far as the reports indicate, these questions have not received a definite determination by any court of last resort in this state. The question of exclusion was, however, considered in the case of *State vs. S. S. "Constitution,"* 42 Cal. 578, to which reference is hereafter made.

Perhaps the most enlightening cases to be found upon the subject of your communication are the so-called "Passenger Cases," decided by the Supreme Court of the United States at the January term in 1849 and reported in the seventh volume of Howard's Reports (48 U. S.) at page 283. The Passenger Cases were two kindred cases argued together before the United States Supreme Court, entitled, respectively, *Norris vs. The City of Boston* and *Smith vs. Turner*. They involved acts of the State of Massachusetts and the State of New York, respectively, relating particularly to the admission within their boundaries of passengers arriving by water at the ports thereof.

Each of the Passenger Cases was argued no less than three times before the Supreme Court of the United States, finally resulting in a decision by a bare majority of the nine justices declaring both the act of the State of Massachusetts and that of the State of New York unconstitutional and, therefore, void because of imposing a burden or regulation upon "commerce with foreign nations, and among the several states, . . ."

(Article I, Section 8, United States Constitution.)

However, in spite of such full argument and careful and lengthy consideration, there was no opinion of the court, as a court, filed in either of these cases. Each of the nine justices, with the exception of Mr. Justice Nelson, filed a lengthy opinion, and Mr. Justice Nelson expressly concurred not only in the conclusions but in the grounds and principles set forth at length in the dissenting opinion of Mr. Chief Justice Taney.

Throughout the report of these cases—covering some 290 pages—are found many and repeated expressions, both in the arguments and in nearly all of the opinions, expressly setting forth and maintaining the right of a state, under its retained police power, to exclude from its boundaries persons arriving thereat from either foreign countries or sister states within the Union where such exclusion was clearly based upon the retained police power and was clearly for the purpose of guarding against the introduction of any thing or person which might corrupt the morals or endanger the health or lives of the citizens of the excluding state.

Upon this principle the report of the "Passenger Cases," *supra*, indicates that every one of the eminent counsel engaged in the argument thereof, as well as every one of the nine justices of the Supreme Court of the United States, concurred.

A few of the many statements found in the opinions of the several justices, and which appear most clearly and definitely in point, will be quoted. For example: Mr. Justice McLean said (page 400):

In giving the commercial power to Congress, the States did not part with that power of self-preservation which must be inherent in every organized community. They may guard against the introduction of anything which may corrupt the morals, or endanger the health or lives of their citizens. Quarantine or health laws have been passed by the states, and regulations of police for their protection and welfare.

Mr. Chief Justice Taney, in his opinion (page 467), said:

I think it, therefore, to be very clear, both upon principle and the authority of adjudged cases, that the several states have a right to remove from among their people, and to prevent from entering the state, any person, or class or description of persons, whom it may deem dangerous or injurious to the interests and welfare of its citizens; and that the state has the exclusive right to determine, in its sound discretion, whether the danger does or does not exist, free from the control of the general government.

Mr. Justice Woodbury, in his opinion (page 525), stated:

The best writers on national law, as well as our own decisions, show that this power of excluding emigrants exists in all states which are sovereign.

He further said (page 528):

Again, considering the power to forbid as existing absolutely in a state, it is for the state where the power resides to decide on what is sufficient cause for it, whether municipal or economical, sickness or crime; as, for example, danger of pauperism, danger to health, danger to morals, danger to property, danger to public principles by revolutions and change of government, or danger to religion.

As to the extension of this right of exclusion to those coming from another state within the Union, Mr. Justice Woodbury further stated (page 529):

As a question of international law, also, they could do the same as to the citizens of other states, if not prevented by other clauses in the Constitution reserving to them certain rights over the whole Union, and which probably protect them from any legislation which does not at least press as hard on their own citizens as on those of other states.

Upon this same point he further said (page 543):

The states have been in the constant habit of prohibiting the introduction of paupers, convicts, free blacks, and persons sick with contagious diseases, no less than slaves; and this from neighboring states as well as from abroad.

Upon this same question, Mr. Justice Mathews of the United States Supreme Court, in delivering the opinion of the court in the case of *Bowman vs. Chicago, etc., Ry. Co.*, 125 U. S. 465, at page 492, quoted with approval from the opinion in the case of *Railroad Co. vs. Husen*, 95 U. S. 465, 471, where it was said:

It may also be admitted, . . . that the police power of a state justifies the adoption of precautionary measures against social evils. Under it a state may legislate to prevent the spread of crime, or pauperism, or disturbance of the peace. It may exclude from its limits convicts, paupers, idiots, and lunatics, and persons likely to become a public charge, as well as persons afflicted by contagious or infectious diseases; a right founded, as intimated in *The Passenger Cases*, 7 How. 283, by Mr. Justice Grier, in the sacred law of self-defense. . . .

Reference should also be made to the case of *Jacobson vs. Massachusetts*, 197 U. S. 11, decided in 1905, in which the Supreme Court of the United States had under consideration questions involving the validity, under the Constitution of the United States, of certain provisions of the statutes of Massachusetts relating to vaccination.

Mr. Justice Harlan, delivering the opinion of the court, said in part (page 28, *et seq.*):

In *Railroad Company vs. Husen*, 95 U. S. 465, 471-473, this court recognized the right of a state to pass sanitary laws, laws for the protection of life, liberty, health, or property within its limits, laws to prevent persons and animals suffering under contagious or infectious diseases, or convicts, from coming within its borders.

See, also, *State ex rel McBride vs. Superior Court* (Wash.), 174 Pac. 973.

That the right of inspection and exclusion extends not only to those presenting themselves at the borders of a state in the course of travel from a foreign port, but likewise to those so presenting themselves by travel from one of the states of the Union to another thereof, seems clearly supported not only by reason, but by authority. In fact it would appear that the only limitation upon such an authorized exclusion is that the provision of law governing the same must not be more burdensome upon the citizens of a sister state seeking to enter the boundaries of

the excluding state than they are upon the citizens of the excluding state itself who have been beyond its borders and seek to reënter; in other words, the same rule must apply to all.

When the law operates alike on all persons and property similarly situated, equal protection of the law cannot be said to have been denied.

Sutherland's Notes on the Constitution, page 729.

It would further appear that this police power of the state should only be exercised when public necessity demands it within reasonable and fair apprehension, and not upon mere suspicion.

29 Corpus Juris, page 253.

In the case of *State vs. S. S. "Constitution," supra*, the Supreme Court of the State of California had before it a proceeding *in rem*, seeking to enforce a lien upon the vessel because of the failure of the owner or consignee thereof to give a required bond or pay requisite commutation money in lieu thereof in connection with certain aliens landed at the port of San Francisco under the provisions of an Act approved May 2, 1852 (Statutes 1852, page 78), and amended by an Act of April 2, 1853 (Statutes 1853, page 71). Mr. Justice Crockett, in delivering the opinion of the court in that case, said in part (page 584):

In considering the grave question here presented, it is to be observed, *in limine*, that whatever may have been the real purpose of the statute, its ostensible purpose was to provide police and sanitary regulations, to prevent the people of this State from becoming chargeable with the support and maintenance of persons imported from foreign countries, who either then were, or were soon after, liable to become a public charge. If it were conceded that this was the real purpose of the statute, and that its provisions are reasonably adapted, and were intended to secure this result, and this only, there would be an end to the argument; for in all the numerous adjudications which have been had in respect to the power of the several states to interfere with commerce under the clauses of the Constitution above referred to, it has never been doubted that a state has the power, by proper police and sanitary regulations, to exclude from its limits paupers, vagabonds, and criminals, or sick, diseased, infirm, and disabled persons, who were liable to become a public charge, or to admit them only on such terms as would prevent the State from being burdened with their support. To surrender this power would be to abandon one of the highest prerogatives of local self-government, one of the chief functions of which is to preserve the public health and to repress crime. . . . The power to make police or sanitary regulations prescribing the terms on which certain classes of persons shall be admitted into this State, necessarily includes the power to exclude them altogether if they fail to comply with the prescribed conditions.

Section 14 of Article XX of the Constitution of the State of California provides:

The legislature shall provide, by law, for the maintenance and efficiency of a state board of health.

The foregoing mandate of the Constitution is complied with in the enactment of Sections 343, 368, 372 to 372g, inclusive, and 2978 to 2984, inclusive, of the Political Code.

Under the provisions of Section 2979 of the Political Code the State Board of Health—the predecessor in power and duty of the Department of Public Health—is expressly required to "examine into the causes of communicable diseases in man and domestic animals occurring or likely to occur in this state."

It is further provided that "it may quarantine or isolate, inspect and disinfect persons, animals, property and things of whatever nature, and houses, rooms, places, cities or localities, whenever in the judgment of said board or pending its meeting, whenever in the judgment of its executive officer such action shall be deemed necessary to protect or preserve the public health; . . ."

It is further provided in said section that "it may establish and maintain places of quarantine or isolation."

Section 2979 further provides:

It shall have general power of inspection, examination, quarantine and disinfection of persons, places and things, within the state, and for the purpose of conducting the same may appoint inspectors, who, under the direction of the board, shall be vested with like powers; provided that this Act shall in no wise conflict with the national quarantine laws.

By the same section authority is conferred "to adopt and enforce rules and regulations for the execution of its duties under this section. . . ."

By Section 2979a of the Political Code it is provided that when the State Board of Health or its secretary is informed as to the existence of certain contagious or infectious diseases (including those of tuberculosis, trachoma, dysentery, and typhoid fever, referred to in your communication) it or he "may thereupon take such measures as may be necessary to ascertain the nature of such disease and prevent the spread of such contagion, and to that end, said State Board of Health, or its secretary, may, if deemed proper, take possession or control of the body of any living person, or the corpse of a deceased person, and may direct and take such means as may be deemed expedient to arrest or prevent the further spread of such disease."

Penalties for crimes against public health and for failure to conform to rules, orders and regulations respecting quarantine or disinfection of persons, are provided by the Penal Code, and particularly by Section 377a thereof.

Sections 12 and 13 of the Act of March 23, 1907 (Stats. 1907, page 893, as amended; Act 6238 of Deering's General Laws, edition of 1931) impose upon every county health officer and every city and county, city or town board of health, or chief executive health officer thereof, the duty of carrying out the directions of the State Board of Health or its secretary, with respect to quarantine and disinfection.

The Act of March 15, 1883 (Statutes 1883, page 376; Act 6243 of Deering's General Laws, edition of 1931) is, as you state in your communication, applicable only to "railroad communication with other states," and can be given no application with regard to those traveling by other means of communication or transportation.

There are, of course, many other acts dealing generally with the health of the people of the State of California and the suppression and control of contagious and infectious diseases, but it is believed unnecessary to advert here to all thereof.

While from the foregoing it would appear clear that the health authorities of the State of California have the right to inspect at the borders those coming from other nations or states into the State of California, and, under the police power, to exclude from the State of California those found to be infected or contaminated with infectious or contagious diseases dangerous to the health of the people of the State of California, it must be remembered that such burdens must be imposed equally and impartially upon all persons so presenting themselves at the boundaries of the State of California for progress into the body of this state. Further than this, any such inspections should only be made or conducted by personnel trained and qualified therefor, and not by persons who are merely peace officers or who are untrained personnel.

A further limitation upon the power of exclusion must also be noted. That is fully and carefully set forth in the reported opinion in the case of *In re Arata*, 52 Cal. App. 380, where, at page 383, it is said:

That the health authorities possess the power to place under quarantine restrictions persons whom they have reasonable cause to believe are afflicted with infectious or contagious diseases coming within the definition set forth in Political Code, Section 2979a, as a general right, may not be questioned. It is equally true that in the exercise of this unusual power, which infringes upon the right of liberty of the individual, personal restraint can only be imposed where, under the facts as brought within the knowledge of the health authorities, *reasonable ground exists to support the belief* that the person is afflicted as claimed; and as to whether such order is justified will depend upon the facts of each individual case. Where a person so restrained of his or her liberty questions the power of the health authorities to impose such restraint, the burden is immediately upon the latter to justify by showing facts in support of the order. It might be proved, for instance, that the suspected person had been exposed to contagious or infectious influences that some person had contracted such disease from him or her, as the case might be. Such proof would furnish tangible ground for the belief that the person was afflicted as claimed. And we wish here to emphasize the proposition, which is unanswerable in law, that a mere suspicion, unsupported by

facts giving rise to reasonable or probable cause, will afford no justification at all for depriving persons of their liberty and subjecting them to virtual imprisonment under a purported order of quarantine.

The provisions of the health laws and regulations must also be reasonable, although to be effective they must be prompt and summary. *County of Los Angeles vs. Spencer*, 126 Cal. 670, 673.

And while Section 2979a of the Political Code, *supra*, confers upon county and other health officers the right to take measures necessary to prevent the spread of disease, but does not confer upon such local health officers the right to take possession of the body of one so afflicted as it does in the case of the State Board of Health, yet nevertheless isolation of one afflicted with an infectious disease has been held to be a reasonable and proper measure to be enforced by local health authorities to prevent the increase and spread of such diseases.

In re Fisher, 74 Cal. App. 225;

In re Johnson, 40 Cal. App. 242.

For the foregoing reasons, and with the limitations set forth in connection therewith, your queries are answered in the affirmative.

Very truly yours,

U. S. WEBB, *Attorney-General*.

(Signed) By LEON FRENCH, *Deputy*.

THE LURE OF MEDICAL HISTORY†

DIPHTHERIA IN 1880: IN SISKIYOU COUNTY

By E. W. BATHURST, M.D.

Etna

IN 1877 I began practicing medicine in Sawyers Bar, Siskiyou County. This small town was dependent upon the near-by mines (placer and quartz) for its existence. Located upon a narrow strip of gravel deposit on one side of the North Fork of the Salmon River, the houses, stores, hotels, and saloons were strung along this strip of gravel for about a mile, the river some twenty to fifty feet below. As the center of the mining activities of the Salmon River section, the little town housed the wives and children of the miners engaged in the Black Bear, Klamath and quartz mines, or who stripped gravel deposits for the auriferous deposits, and was fairly prosperous. When you reached Sawyers Bar you had attained "the jumping off place," for there was no way of communicating with the outer world but by trails, over which pack-trains brought in merchandise (liquid and solid), together with our six-day mail service from Etna. In the winter, mail was transported on webbed snowshoes, a perilous job not unattended by fatalities. The nearest supply of drugs was in Etna, some twenty-six miles away, a two days' trip by mule-back, hence it behooved the Sawyers Bar medico to keep a stock of medicines on hand, particularly as there were no trained nurses, and the nearest consultant was at Etna; so at least the location taught self-reliance.

The mountainous country was well drained, the streams did not glide placidly over nearly level

†A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

bottoms, but hurried and scurried down the ravines to swell the North Fork of the Salmon which, in turn, joined the South Fork at the "Forks of the Salmon," when the stream of added volume wended its way to Somes Bar, blending its waters with the Klamath River. At that point, four rivers empty into the Klamath on the south side—Shasta, Scott, Salmon, and Trinity—and these drain a vast precipitous watershed. On the north side of the Klamath are numerous large creeks that empty into the main river—creeks that in summertime surpass the Los Angeles River. Fishing is good—mountain trout just after May 1 of each year—while later it is not so good. In the fall, well, we have steelheads and salmon, as the papers detail; also the largest fish hatchery in the State. So, come up after the first fall rains and enjoy our fishing.

THE DIPHTHERIA EPIDEMIC

But this does not describe a diphtheria epidemic as handled at and around Sawyers Bar in 1880. School was out, summer was in full swing, when I was called to see a child with diphtheria. The kindly neighbors sought to help the afflicted families, so the disease spread quickly; there was no quarantine, little segregation, the days were warm if not hot, the buildings not closely together, abundant good air and water, but the type of the disease was what my forebears termed "*Putrid sore throat*." Those afflicted with it positively stank, so I do not doubt that if George Washington had this type he either died of toxemia or phlebotomy—*quien sabe?* The fauces and nasal passages were thickly coated with a yellow, cream-colored, thick membrane; temperature not over 101 degrees, patient stolid, embarrassed breathing due to pharyngeal engorgement, and a horrible odor—so bad that, despite the liberal use of chlorid of lime and phenol, our only available disinfectants, it was impossible to stay in the room with the patient. I have correctly diagnosed this type of diphtheria before I entered a room merely by the odor. Some cases occurred at Black Bear Mine, some seven miles away, where one baby had an inflamed neck (intertrigo); this became infected, and despite local treatment plus internal medication, the toxemia proved fatal—a fact not to be wondered at, perhaps, since in this home, on a sidehill, high off the ground with nothing but posts to rest upon, the wind swept daily, and butter stored in a keg became contaminated and inedible.

A Welsh boy was treated. I had to have an old-time Cornish woman translate the Welsh language pertaining to the case to me. For about six weeks I did not go to bed, but laid down where I happened to be, on cot or lounge, to be called two hours later to go and visit new patients or revisit the older ones.

TREATMENT

The remedies used, aided by the pure mountain air and clear cold water, consisted principally of iron internally and application of Loeffler's solution locally; a typical treatment for a ten-year-old child being:

R Tincture of Ferri Chloridi 5ii
Glycerin flid. ʒiv

A teaspoonful was given every three hours without water, preceded by an initial dose of calomel, five grains. The throat was painted every time I got around to do it, using Loeffler's solution on a swab. A small amount of whisky was given, if indicated. The iron mixture, given undiluted, was to coat the fauces as well as combat the infection. I soon learned that if the iron turned the membrane black the patient got well, which happened with the majority, for out of the 110 cases only five died; so that with no skilled nurses, no antitoxin, I think the results were good. I know everyone coöperated and shared each other's sorrows.

Loeffler's solution contains 4 per cent ferric chlorid solution, so we weathered through the epidemic—houses and clothing aired and, as far as possible, disinfected. In later years I have wondered if a like treatment would be of service in serious diphtheritic infection to aid antitoxin in its work—there being with us only one case of laryngeal involvement.

CLINICAL NOTES AND CASE REPORTS

GAS-GANGRENE INFECTION OF THE UTERUS

By ALBERT H. NEWTON, M.D.

AND

ROY F. SCHLAPPI, M.D.

Yreka

GAS-GANGRENE infection is one of the most serious complications met with in modern surgery. A search through the available literature on the subject, involving the uterus, reveals the infection to be practically 100 per cent fatal. In dealing with this type of infection, one must be radical in surgical treatment and early radical removal of the internal genitalia, with massive doses of antitoxin, plus supportive treatment, will probably result in an occasional saving of human life.

REPORT OF CASE

We wish to report the successful cure of a gas-gangrene infection, involving the uterus of a three and one-half months pregnant woman, Mrs. L. M., married, age 26; occupation, housewife; American; white; para, two.

The above-named patient was brought to the Siskiyou County General Hospital at 6 p. m. February 23, 1935, with a complaint of chills, high fever, severe abdominal cramps and general malaise.

Past History.—Born in Utah. Lived in California nineteen years. Measles and mumps in childhood. Previous surgery: Curettment following childbirth, and perineal repair three years ago. Tonsillectomy several years ago. Husband living and well. Two children living and well, ages four and three. Cta.: Menses began at fourteen, every 28/5. No dysmenorrhea. Last normal period, November 6, 1934. Other systems essentially negative. Family history essentially negative.

Present Illness.—The patient's last normal menstrual period was in November, 1934. The patient was told, following an examination on or about December 25, 1934, that she was two months pregnant. On February 21, 1935,

the patient attempted to induce an abortion, using the following technique: She douched the vagina thoroughly, sterilized a piece of elm bark, six or eight inches in length, by dipping it in boiling water, wrapped the tip with cotton and inserted the instrument into the uterus by the vaginal route. The patient states that she fainted at this time, and upon revival she withdrew the foreign body. Bloody vaginal flow followed a few hours later, and on the following day she experienced severe abdominal cramps. On the morning of February 23 she began to have chills and fever. The abdominal cramps became more severe, and she was brought to the hospital at 6 p. m.

Examination and Surgical Procedures.—Examination revealed a medium-statured woman of twenty-six years, sobbing and crying with pain. Temperature was 104 degrees Fahrenheit. Pulse 160 per minute, regular, but of poor quality. Respiration was 20 per minute. The patient appeared quite toxic; the mucous membranes were extremely pale. The chest revealed no pathology. The abdomen was flat, with marked rigidity of the lower abdomen. Pelvic examination revealed an approximately three and one-half months fetus, partially expelled from the uterus into the vagina. The tissues of the fetus were macerated and gave an extremely foul odor. Much foul gas was expelled from the uterus, upon introducing a weighted speculum into the vagina. There were present in the canal of the cervix and on the fetus numerous one-half centimeter blebs containing serum and gas. Under gas anesthesia, the uterus was curetted free of its contents, including a placenta that was filled with small blebs containing serum and gas. This procedure was accompanied with considerable hemorrhage. Smears were taken from the fetus, placenta, and the cervical canal, at this time, and the vagina was then temporarily packed with sterile gauze. Laboratory report of the smears showed a pure strain of gas bacillus presenting the usual morphology. One therapeutic dose of polyanerobic serum (*B. welchii* 10,000 units, *B. sordellei* 50,000 M. L. D., *Vibrio septique* 10,000 units, and *edematiens* 50,000 M. L. D.) was administered intramuscularly, and 1,000 cubic centimeters of normal saline, containing 5 per cent glucose, was given subcutaneously. Blood count at this time was 2,700,000 red blood cells; hemoglobin, 50 per cent. Blood pressure was 90/30. Pulse 140 per minute, regular, poor volume. Blood donors were obtained, and 500 cubic centimeters of citrated whole blood, containing a second therapeutic dose of antitoxin, was administered intravenously. Following this, blood pressure rose to 110/60, pulse 120 per minute. The patient was transferred to surgery at 8 p. m., and under low spinal anesthesia a vaginal panhysterectomy was performed. The uterus, fallopian tubes, ovaries, including one inch of the uterine attachment of the broad ligament, were dissected en masse (in one piece), the dissection being carried laterally quite widely into the edematous broad ligaments, round ligaments, and uterosacral ligaments. The peritoneum was then closed with a purse-string suture of plain catgut, the divided ends of the round ligaments, broad ligaments, and uterosacral ligaments were sutured together, slinging the same beneath the bladder. The fascial planes were then united with chromic catgut and silkworm gut sutures. The patient withstood the operation satisfactorily, pulse remaining 120 to 130, blood pressure 110/60. Examination of the pathologic specimen revealed the uterus, tubes, ovaries, and parametrial tissue to be filled with blood and lymph. The cervix was markedly congested with lymph.

Four hours following surgery, a third therapeutic dose of polyanerobic antitoxin was administered intramuscularly, and at 9 a. m. on the following morning a fourth therapeutic dose of antitoxin was administered, and 300 cubic centimeters of whole citrated blood was given intravenously.

Postoperative Course.—The patient ran a mild septic fever for four days, postoperative, with pulse ranging from 100 to 120 per minute, following which the temperature curve approached the normal, with pulse coming down to 70 to 80. The patient developed some serum sickness five days postoperative, which was controlled with adrenalin. Physical examination on March 5, 1935, revealed the following: The patient appeared rather anemic; had no system complaints; lung fields were clear; heart

rate was 64, regular. Blood pressure was 120/80. Abdomen was soft and flat. Some tenderness to deep palpation in the lower abdomen. Pelvic examination revealed the wound in the vaginal vault to be healed by primary union. Silkworm gut sutures were removed.

Laboratory Report.—Urine was negative. Red blood cells, 3,700,000; white blood cells, 8,800; normal differential. Blood Wassermann was negative.

Report of examination of slides taken at the time the patient was curetted, from the Department of Public Health, State of California, Bureau of Laboratories, is as follows: "We received the slides and examined them, after staining by Gram's method. They showed numerous Gram-positive bacilli, having the usual morphology of organisms of the gas-gangrene group. (Signed) W. H. Kellogg, M. D., Chief of the Bureau of Laboratories."

The patient was discharged cured on March 8, 1935.

COMMENT

Successful cure of gas-gangrene infection is reported: Case, a three and one-half months' pregnant uterus, with radical vaginal panhysterectomy; plus 40,000 units *B. welchii*, 200,000 M. L. D. *B. sordellei*, 40,000 units *vibrio septique*, and 200,000 M. L. D. *edematiens*, and 800 cubic centimeters of whole citrated blood, and 3,000 cubic centimeters of normal saline with 5 per cent glucose; the antitoxin, blood and fluid being administered over a period of twelve hours, preceding and following surgery.

168 Miner Street.

PAIN ALLEVIATION IN INOPERABLE MALIGNANCY

By H. S. PENN, M.D.
Los Angeles

IN a recent communication¹ Doctors Walter B. Coffey and John D. Humber described their experience with an aqueous suprarenal extract in the treatment of malignancy. I wish to refer to that part of the paper dealing with the pain-alleviating properties ascribed to the extract, and its action on the blood cholesterol.

During the past four years I have used, among other preparations, aqueous extracts of the suprarenal, thyroid, and spleen in cases of inoperable malignancy. These were prepared by extraction of the ground-fresh tissue in normal saline, made slightly alkaline with NaOH. After a twenty-four hour extraction, a precipitate was effected by adding .2 per cent acetic acid, or acetone. In case of the suprarenal gland, the solution was first treated with ammonium hydroxid (to precipitate out medullary products) filtered and then followed by .2 per cent acetic acid. The protein mass consisting chiefly of globulin and allied substances was centrifuged, dissolved in normal saline in 1:100 ratio, brought up to a pH 7.5 and filtered through a Seitz filter. To this filtrate .4 per cent tricresol was added. It was noteworthy that, although these preparations came from three different sources, the pain-alleviating property was common to all. The action of some of these preparations was more pronounced than that produced by opiates. On several occasions pain disappeared within a few minutes after injection, and was for as long as from four to six hours.

A plausible explanation of this phenomenon may rest on the fact that the globulins and allied substances are combined with the phosphatids.² It is conceivable that the latter may be responsible for this palliative action. This contention is based on the results obtained in a limited number of cases of inoperable malignancy, where phospholipin emulsion was used. Its pain-alleviating action was quite pronounced. Where such palliation did occur, the patient was free from pain from twenty-four to forty-eight hours. It would seem, then, that this attribute of pain alleviation cannot be made a specific property of the suprarenal extract.

Concerning the effect of the suprarenal extract on blood cholesterol it was found by a number of investigators³ that feeding whole thyroid, KI, and certain fractions of the phosphatids produced the same result. In addition I had an occasion to observe in a limited number of trials, both animal and human, that, after repeated injections of the suprarenal extract, the blood cholesterol returned to its original level within ten to fourteen days. This manifestation is also observed after a prolonged use of certain phospholipins.

Incidentally, I wish to state that at no time have I noted definite retrogressive changes in malignant growths after the administration of the glandular aqueous extracts, either in humans or in experimental animals (Flexner Jubling rat carcinoma).

1225 Roosevelt Building.

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BLADDER IRRITABILITY DUE TO CARELESS OPERATIVE TECHNIQUE

By H. VERRILL FINDLAY, M.D.
Santa Barbara

I WISH to cite two recent experiences which may serve as a timely warning to those who are performing surgery in regions adjacent to the bladder. Symptoms of disturbed urination following various types of pelvic surgery, especially in the female, are not uncommon. Fortunately, the vast majority disappear in a brief time after appropriate simple treatments are given. There is, however, a small group of patients whose persistent, annoying bladder symptoms make their life most miserable. They are frequently passed between gynecologist and urologist without receiving any real or lasting benefit. Only those of us who have had patients of this type can know the misery which they endure and the futility of our efforts to relieve them.

The majority of these patients have their post-operative symptoms because of ill-chosen or poorly performed surgery. Under the former grouping, one might mention the many women whose urinary

frequency had been unaffected by a perineal repair and uterine suspension because the symptoms were entirely due to a contracted bladder resulting from a chronic cystitis of many years' duration.

I wish to comment particularly, because of two patients whom I have recently seen, on the individuals having persistent bladder symptoms due to faulty operative technique: One had been operated upon by a urologist and the other by a gynecologist.

REPORT OF CASES

CASE 1.—The first patient, a woman of fifty-five, came to me because of "severe bladder cramps," which would occur periodically and persist intermittently for as long as three days. She could determine no exciting factor except constipation. Her symptoms began some three months following an exploratory laparotomy ten years previously. She thought her uterus had been removed at that time. Examination of her pelvis revealed a firm, slightly tender mass, which might have been either an atrophic uterus or a generous cervical stump with numerous adhesions. A catheterized urine specimen showed no pus. When the bladder was filled with 200 cubic centimeters of sterile solution she would complain of its aching, but did not have any spasmodic voiding. At cystoscopy the bladder appeared normal.

This patient continued to be miserable and, at her request, her abdomen was explored. At the previous operation a hysterectomy had been done, and the stump of the cervix had become fixed rather high on the bladder wall, toward the fundus. I could not determine whether it had been fixed there originally or had become attached by adhesions. This cervical attachment was so situated that, as the bladder filled, it seriously interfered with the normal expansion of that organ, and was undoubtedly the cause of her symptoms. When this attachment was freed, the cervix descended and the bladder was able to expand normally.

• • •

CASE 2.—The second patient, a seventy-year-old woman, had a desire to void when lying down and, on answering the urge, could produce only a small quantity of urine. The symptoms were scarcely noticeable when standing. She had had a partial excision of the bladder for a "chronic ulcer" some twelve years previously, and the present symptoms dated from that time. Cystoscopy revealed nothing abnormal, except a mild trigonitis. I performed a peritoneoscopy with the Ruddock peritoneoscope, and found that the uterus lay in a horizontal position, and was firmly attached to the entire dome of the bladder. It was fixed so that the fundus of the uterus almost touched the symphysis. When the bladder was filled the uterus kept approximately this same position. When the patient was placed in a Trendelenburg position, with the bladder empty, the uterus could be seen to have tilted slightly backward, producing some tension on the bladder. With the uterus in this position, the patient had a painful desire to void, but when encouraged to do so, could not. When she was replaced in the horizontal position the uterus was seen to fall forward, and the patient was immediately relieved of her symptoms.

COMMENT

This first woman had urinary symptoms because of faulty fixation of the cervical stump, following hysterectomy. The second patient had her symptoms because the uterus had apparently been used to close or reinforce a defect in the dome of the bladder.

I cite these two experiences to show the misery which patients may be forced to endure because of faulty or careless surgery done in the pelvis. Though the bladder is an elastic organ capable of remarkable regeneration and adaptation, it should, none the less, be treated with proper surgical consideration by both gynecologist and urologist.

1515 State Street.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

DERMATITIS VENENATA

I. ETIOLOGY

SAMUEL AYRES, JR., M.D. (2007 Wilshire Boulevard, Los Angeles).—The old term "dermatitis venenata," signifying "an irritation of the skin due to a poison," is gradually being replaced by the more accurate designation, contact dermatitis, or an eruption due to contact with some irritating substance, not necessarily a poison in the ordinary sense. It should be clearly understood at the outset that contact dermatitis, while sometimes spoken of as "contact allergy," is in no way related to atopic allergy, which is an inherited tendency to become sensitized to foreign proteins in foods, pollens, epidermal derivatives, etc., and manifests itself as the eczema-asthma-hay fever complex. While dermatitis venenata often appears as an eczematous type of eruption, it has many points of difference from an eczema of the inherited atopic allergy type. So far as known, dermatitis venenata, or contact dermatitis, is not associated with asthma or hay fever any more frequently than the law of chance would account for, it is not inherited, and any normal non-sensitive individual can become sensitive under certain circumstances. The fact that an individual has been in frequent contact with a certain substance for many years without suffering inconvenience is no argument against the present eruption being due to that substance. The mechanism by which a person suddenly develops a sensitivity to a substance to which he was formerly immune is not known.

A list of the substances which have been proved at one time or another to have been actually responsible for cases of contact dermatitis is almost inexhaustible, and no substance, however commonplace or innocuous appearing, should be overlooked in considering the cause of a given case of dermatitis. There is probably not another field of medicine in which the amateur detective has a better opportunity of proving his skill. An exhaustive cross-examination and a close scrutiny of all available evidence, with attention to the minutest detail, will often uncover clues which will point to the offending agent.

Not so many years ago, in the days before the employment of patch tests, the known causes of dermatitis venenata were relatively few. Poison ivy in the East and the Middle West, and poison oak on the Pacific Coast, were the principal known causes of the disorder, and still rank high as etiologic agents. Fixed oils, lobinol in the case of poison oak and toxicodendrol in the case of poison ivy, are the offending substances, and actual contact with the plant or some product thereof is necessary for the development of a dermatitis. The pollen of these plants, however, is capable of

producing the eruption, so that it would be possible for a person to develop an attack of poison oak without actually touching the plant itself. Dermatitis is also reported to have resulted from contact with smoke from a bonfire in which the plant was burning.

It is believed that most cases of dermatitis due to contact with plants are caused by an oil. While poison oak and poison ivy are the greatest offenders, other plants are relatively frequent trouble makers, while still others only on rare occasions produce a dermatitis. *Primula obconica*, the lovely pink primrose, has achieved a certain reputation for bad behavior. The oil of ragweed or other weed pollen may cause a severe contact dermatitis of the face, while the same individual may be entirely unaffected by the protein fraction and suffers no inconvenience from asthma or hay fever, which are manifestations of protein sensitivity. In California some of the plants which have been known to have caused contact eruptions are lantana, English ivy, geum, wigandia, geranium, chrysanthemum, snapdragon, etc. Among the weeds, Western, slender and false ragweed, and camomile are well-known offenders, especially the former. Cases of dermatitis from various kinds of wood, such as redwood, pine, mahogany, ebony, etc., have been reported. We have seen dermatitis of the fingers and hands from squeezing oranges and lemons, and caused by an oil in the peeling.

The causes of dermatitis venenata among various trades and industries are as varied and as changing as the industrial processes themselves. An excellent reference book for eruptions of this type is R. Prosser White's "Dermatogoses," or industrial dermatoses. It would be far beyond the scope of this paper adequately to discuss the causes of dermatitis in the industrial field. Oils, paints, dyes, lacquers, lime, metals, leather, and chemicals of all sorts and descriptions must be considered.

Some of these substances occur sufficiently often in fields of general activity to merit some discussion. Among the metals, nickel is probably the greatest offender; and inasmuch as nickel is contained as an alloy in "white gold," many cases of nickel dermatitis have been traced to wrist-watches, rings, eyeglass frames, hair curlers, metal garter pieces, etc. Metal polishes are almost universally irritating, and frequent contact with them would be likely to irritate even a relatively non-sensitive skin.

We have observed several interesting cases of dermatitis due to leather in various locations: the forehead from hat-band and head-mirror leather, the buttock and thigh from a leather wallet carried in the hip pocket, feet from shoe leather. Both dyes and chemicals employed in processing the leather can cause trouble.

We have encountered cases of dermatitis due to paints, dyes, lacquers, etc., of non-industrial origin, as follows: "toilet-seat dermatitis" due to the finish on a toilet seat; lacquer dermatitis from contact with lacquered wood such as Mah Jongg sets; dermatitis from dye in clothing, hair dye, etc.; eruptions of the hands and sometimes of the face from printer's ink on ordinary newspaper or rotogravure supplements.

Irritation from chemicals used in photographic developing illustrate how hobbies must be investigated as well as trades and industries.

Cosmetics are responsible for many eruptions, especially in women, and again let it be emphasized that a cosmetic which a patient has used for years is just as likely to be the offending substance as a new cosmetic. From a medico-legal point of view it is well to remember that unless a given cosmetic causes an unwarranted number of reactions to patch tests in normal individuals, an infrequent eruption due to the cosmetic is to be regarded in the same light as a personal idiosyncrasy to any other substance and should not carry any implication of negligence on the part of the manufacturer. But it is the rare case of sensitivity which the physician is called upon to recognize. Any type of cosmetic may be responsible, and the list to be investigated should include hair dyes, hair-waving solutions, hair tonics, shampoos, rinses, face powders, cold creams, lotions, shaving lotions, shaving soaps and creams, astringents, bleaches, rouges, lip sticks, eye shadows, eyebrow pencils, mascara, perfumes, and dentifrices. Tooth paste may or may not be considered a cosmetic, but certain brands, especially those containing hexyl-resorcinol (S. T. 37), have been reported as causing an irritation of the lips and sometimes even of the fingers. Perfume dabbed on the neck or behind the ear may not cause a dermatitis until acted upon by the sunlight.

Many other medicinal or semi-medicinal substances which are used externally have been known to cause dermatitis. The following may be included in this list: mouth washes, gargles, nose drops (ephedrin, essential oils, etc.), eye drops, liniments, massage oils (oil of eucalyptus, camphor), alcohol rubs, excessive bathing (especially in cool, dry weather in elderly people), medicated soaps, finger-nail polishes and polish removers, douches and contraceptives, many proprietary salves and lotions, especially those containing mercury, butescin picrate ointment, ointments containing various types of local anesthetics, etc.

Physicians and dentists developing eczematous eruptions of the hands should consider local irritation from novocain, antiseptic solutions, rubber gloves and glove powders.

Urine retained in contact with the skin may cause the so-called diaper dermatitis of infants which is believed to be due to a decomposition of the urine by skin or fecal bacteria with the liberation of ammonia and resultant irritation. A similar process affecting the glans penis may be observed occasionally in men who, after urination, allow a drop of urine to be retained under the foreskin.

Wool clothing, silk, horse hair or dander and other epidermal derivatives may cause dermatitis, either by contact (in which it is a true case of contact dermatitis), or by inhalation, resulting in an atopic sensitivity with a clinical reaction manifesting itself either as eczema, asthma, or hay fever.

While yeasts, molds, fungi and other infectious agents usually produce their effects by parasitic action on the skin, or by absorption of their toxic products (so-called "allergy of infection"), with the development of "id" eruptions, cases of contact sensitivity to yeasts and fungi have been reported in which strongly positive patch tests were obtained to kill extracts of the organisms.

Finally, two cases may be briefly cited to illustrate totally unsuspected sources of irritation. One patient, a girl about sixteen years old, presented a vesiculo-crusted eruption of the face which at first suggested a milium type of impetigo. Finally satisfying ourselves that the condition was noninfectious, we began a series of patch tests with cosmetics. Only the adhesive tape used in making the patch tests caused reactions, and these were severe and similar to the eruption of the face. Testing separately the ingredients of adhesive tape, the patient reacted only to the rosin. The patient then remembered that for several weeks she had been taking esthetic dancing lessons and that rosin was sprinkled on the floor. She frequently sat on the floor to change her dancing slippers, using her hand to wipe the perspiration from her face. As long as she remained away from the dancing lessons her face remained well. We have subsequently discovered that substances containing rosin or resinous derivatives such as waxes, furniture polish, floor wax, automobile wax, etc., are occasional causes of eruptions.

The other patient was also a young girl who developed an acute dermatitis in the bends of the elbows and adjacent portions of the arms. Close questioning and patch tests finally revealed that the eruption was caused by ordinary brown wrapping paper covering some groceries which she had carried home from the store, holding the package in the bend of the elbow. A patch test with the wrapping paper produced a blistering reaction.

* * *

II. DIAGNOSIS

H. J. TEMPLETON, M. D. (3115 Webster Street, Oakland).—Four factors are to be considered when making the diagnosis of dermatitis venenata, namely, the morphology of the eruption, the location of the eruption, the patient's history, and the results of patch testing.

Morphologically, the clinical picture of dermatitis venenata varies from the transient erythema or chapping of the hands seen, following exposure to such irritants as gasoline up through the acute vesiculo-bullous eruption of poison oak to the thickened crusted fissured chronic dermatitis of the hands of painters who have been exposed daily to paints or turpentine to which their skins are sensitive. Therefore, we may say that there is no one uniformly typical clinical picture of dermatitis venenata. Probably the one most diag-

nostic picture consists of the streaks of vesicles produced where twigs of poison oak have brushed across the skin or where the same result has been produced by the spreading of the oleoresin by the patient's scratching.

The location of the eruption has been, in my experience, the most valuable diagnostic point. In general the lesions of dermatitis venenata have been limited to the face, neck, and arms, that is, as one would expect, to areas which could easily come in contact with external irritants. An acute eruption on the scalp might be caused by sensitization to quinin, or chloral in a hair tonic or to hair dyes. A dermatitis sharply limited to the upper half of the forehead would make one think of a hat-band dermatitis. The very common dermatitis of the eyelids should raise suspicion as to eyelash darkeners or cosmetics in general. Facial location immediately suggests that the dermatitis is due to powders, rouge, or cold creams. For example, a student had been the rounds of the dermatologists and allergists of the Bay district because of an intractable facial dermatitis which we had been unable to relieve. One day he burst into my consultation room almost shouting, "Doc, I've found it! Every time I go 'necking' my face breaks out." He was sensitive to orris root in his girl's face powder. Localization on the neck may mean sensitization to fur pieces, to painted beads, to scarfs. Dermatitis of the hands and arms generally means, I believe, sensitization to some external irritant. Cases have been reported of sensitivity to almost anything with which the hands come in contact. Housewives' dermatitis due to soap and water, the dermatitis of the surgeon due to scrubbing or to iodine or mercury, the dentist who is sensitive to novocain, the laboratory worker sensitive to formaldehyde, the nurse sensitive to denaturants (quinin, etc.) in rubbing alcohol, the painter sensitive to "turps," the florist or amateur gardener sensitive to primroses, chrysanthemums, or other flowers, the orange-stand girls sensitive to orange peel, the bank teller sensitive to nickle in coins—the list could be almost endless, drawn from one's own experience. A few bizarre locations and causes might be of interest. Location on the ear lobes and between the breasts pointed the way to diagnosis of a dermatitis venenata due to perfume. Dermatitis under garter clasps was proved to be due to nickle. A police officer developed a dermatitis under his upper vest pocket from irritation from a tear-gas tube. Similar to this is the frequently seen match-box dermatitis, which is situated under vest or pants pockets in which matches are carried.

The patient's history will often give the clue which discloses causes such as mentioned above. But in taking it one must be possessed of both patience and detective ability. One point, which I think is very important, has to do with a story of alternating periods of recovery and relapse. For example, if a patient states that his dermatitis began when he started work as a soda-fountain attendant, disappeared while on a vacation from such work only to relapse when he resumes his

duties, one would be especially inclined to consider the likelihood of the dermatitis being due to contact with something at the soda fountain.

Although not infallible, patch tests are of considerable value in diagnosing dermatitis venenata. Stripped of all unnecessary technicalities, this test simply means applying to a patient's skin the substance to which you think he may be sensitive and observing the result. Of course, if the substance is an irritant to any normal skin, it must be diluted with a nonirritating diluent down to the point where it will not irritate a normal control. All of the equipment that is necessary for the performance of the test is the substance suspected, pieces of cloth about one and one-half inches square, and rubber cement. A bit of primrose, a dab of cosmetics, a few drops of hair tonic or any other suspected substance is placed on the skin and covered by the cloth square, whose edges are fastened to the skin by the rubber cement. The patch remains in place for twenty-four hours, after which the skin is observed for evidence of erythema or vesiculation for several days. A positive test raises suspicion, but a negative test may mean only that the area to which the test was applied (generally back, thigh, or arm), was not sensitive, whereas the area involved by the dermatitis might have reacted vigorously had we dared apply the test at that site.

* * *

III. TREATMENT

HARRY E. ALDERSON, M. D. (490 Post Street, San Francisco).—The following recommendations apply only to the treatment of dermatitis venenata due to poison oak exposures. Naturally, dermatitis due to other contacts calls for entirely different measures. We have seen many cases of scabies and dermatitis due to other causes than poison oak that had been unsuccessfully treated with poison-oak remedies. In these cases the physician and the patient both cited their failures as proof that the plant toxin by mouth and by injection was of no use. Unfavorable criticisms of the method has been based often on wrong diagnoses and improper carrying out of the treatment. It must be remembered that individual skins differ greatly in their vulnerability and in their ability to recover promptly from an injury. This is seen in the very young, the aged, and in persons suffering from various metabolic disturbances. So local therapy has to be modified to meet the requirements of each case at different stages of the dermatitis.

In 1918, in accordance with Schamberg's suggestions, the writer of this article tried out the poison-oak toxin on a large number of cases at the Letterman General Hospital in San Francisco.¹ An alcoholic extract made from the leaves and twigs of the young plant was given by mouth and by intragluteal injection for curative as well as immunizing purposes. By giving the toxin in ascending doses, increasing tolerance for the poison was produced. This method had been carried out crudely by natives and Mexicans for many years, with more or less success. So popu-

¹ Alderson, H. E.: Notes on Skin Diseases Observed at the Letterman General Hospital, Calif. St. J. Med. (Oct.), 1920.

lar did the method become that concentrated and dilute solutions of the toxin for intramuscular and oral administration were placed on the market by at least six manufacturers.

Immunization Therapy.—By giving an intragluteal injection of the concentrated extract and then administering the dilute solution in daily ascending dosage for a month, a high degree of tolerance for the poison is built up. The dosage varies with the preparation. With the dilute alcoholic solution of poison oak it is customary to start with ten drops in water in the morning, eleven at noon, and twelve in the evening. In this manner the dose is increased by one drop each time until thirty drops are being taken three times daily. At this point we stop the drop dosage and give the preparation only once a day in two teaspoonfuls dosage. It is important to continue this for at least a month. Some very susceptible individuals take it all the time they are in poison oak territory. We have observed no ill effects, and believe that the occasional phenomena reported by others are most likely due to other causes. We can state that in our very extensive experience (from 1918 to date), we have never seen a case where we felt that a spread of the eruption could be attributed to this treatment.

Active Internal Treatment.—In the presence of an acute attack with much swelling and discomfort, we inject one cubic centimeter of the concentrated extract intragluteally and repeat in twelve hours if there is no relief. Rarely do we give a third injection. Frequently there is relief of the local symptoms within twelve hours, and after that, subsidence of the dermatitis is rapid. It must be remembered, of course, that underlying bodily conditions, and also the inherent tendency that some skins have to become eczematous when irritated by any agent, may prolong inflammation for some days after the poison oak dermatitis has subsided.

We realize that the injecting of the concentrated toxin in the presence of an acute poison oak dermatitis has not proper scientific foundation, but strikingly beneficial results are seen so often that they must impress one.² Dr. Merlin Maynard of San Jose has observed some good results in these acute cases from autohemotherapy. It is possible that we have here a "shock effect." However, I feel that the toxin is an important factor. Certainly, the itching and the inflammation are relieved early. As many of these patients are nervous, restless and itchy, it is occasionally necessary to give sedatives. Bromids, small doses of aspirin or of amytal (grain three-fourths) are very helpful. Naturally, rest in bed helps also.

Local Therapy.—As toxicodendrol is neutralized and dissolved by soaps, alkalies, and alcohol, early cleansing of the entire skin surface with these agents will render the poison on the surface harmless. At times patients have the mistaken idea that bathing is injurious and spreads the disease. Where lesions appear in spite of cleansing measures, it is because the poison has already

penetrated deeply enough to produce a reaction. Another prevalent mistaken idea is that fluid from the vesicles and bullae will spread the dermatitis. Inoculation experiments have proved that this is impossible.

Where there is much inflammation and edema, cold compresses of Burrow's solution, boric acid or magnesium sulphate solutions are very useful. When the edema is reduced, compresses of potassium permanganate aqueous solution (1-15,000) are recommended. As long as there is edema and exudation, compresses should be continued. Tincture of the chlorid of iron applications help the milder cases, but sometimes this produces annoying pigmentation. In the acute stages, greasy preparations are not desirable. The following lotions are beneficial:

R	Phenol	1.0
	Zinc oxid	16.0
	Lime water q. s. ad.	180.0
M.	Sig. Apply often.	
R	Resorcin	1.8
	Acid boric	7.0
	Alcohol q. s. ad.	180.0
M.	Sig. Apply and follow with talcum powder.	
R	Spirits of camphor	30.0
	Lotio calamin q. s. ad.	180.0
M.	Sig. Apply often.	

Dr. William Donald of Berkeley found, years ago, that application of liquid air on swabs would relieve the itching, and the inflammation would subside more rapidly afterward.*

As the inflammation somewhat subsides and the skin becomes dry, various ointments or liniments as used in eczema are indicated, as follows:

R	Juniper oil tar	1.5
	Lanolin	30.0
	Unguent zinc oxid q. s. ad.	60.0
M.	Sig. Spread on smooth cloths and apply.	
R	Menthol	2.0
	Liquor carbonis detergens	12.0
	Calamin liniment q. s. ad.	240.0
M.	Sig. Apply freely.	

The tar may be increased in amount if it is well tolerated.

Prophylaxis.—As stated in the first part of this paper, a high degree of tolerance can be developed by giving the dilute toxin ("immunizing solution") in ascending doses for a month or more. A hot alkaline bath, with plenty of soap and thorough dry cleansing of clothing worn when exposed, will eliminate most of the poison. An alcohol rub following the alkaline bath is recommended. As household pets running in the woods and fields may carry and retain the toxicodendrol for a long time on their hair, it may be well to have them thoroughly bathed. Another source of exposure is firewood and greens that are brought into the house.

While the toxin treatment is not 100 per cent effective, it is valuable in a very high percentage of the cases. Any treatment that is even 50 per cent efficient is worth while.

² Alderson, H. E.: Treatment of Poison Oak Dermatitis (with discussion). Calif. and West. Med. (Aug.), 1925.

* See discussion in CALIFORNIA AND WESTERN MEDICINE, August, 1925.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

EDWARD M. PALLETTE President
 HOWARD MORROW President-Elect
 W. W. ROBLEE Speaker
 MORTON R. GIBBONS Council Chairman
 FREDERICK C. WARNSHUIS Secretary-Treasurer

THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. WPA Medical Service Policies.
2. County Secretaries' Conference.
3. Amendments to the Constitution.
4. Ill-Advised Resolutions.
5. Del Monte Annual Meeting.
6. Officers and Committees.
7. Paragraph Reminders.
8. One Thousand Dollar Fees.
9. Skeet Contest.
10. Council Minutes.

DEPARTMENT OF PUBLIC RELATIONS

1. Legislation.
2. It Is Happening Elsewhere.
3. Medical and Legal Professions.
4. Syphilis.

ASSOCIATION ACTIVITIES

WPA MEDICAL SERVICE POLICIES

Latest information indicates that the following divisions of the WPA are directed through a central office in San Francisco.

- Resettlement Administrations.
- National Youth Administrations.
- Recreational Demonstrations.
- Work Camp Project, National Parks.

The WPA has no jurisdiction whatever over accidental injuries involving security workers employed by federal agencies such as the Army, Navy, Coast, and Geodetic Survey, even though these workers are certified by relief authorities or secured from the same sources that WPA workers are secured.

The department is governed by and operates under the rules and regulations of the United States Employees' Compensation Commission. The United States Compensation Commission and not the California Accident Board is the sole and final authority in instances of accidental injury.

Benefits arising through the Federal Compensation Act are extended solely to workers receiving *traumatic* injuries in the course of their work. Federal medical and surgical facilities must be employed wherever they are available.

When federal medical facilities are not available, then only licensed doctors of medicine may be called. The Commission recognizes only licensed physicians and surgeons.

The WPA has no closed panel of physicians and surgeons. All qualified, competent doctors of medicine are eligible to render service when federal facilities are not available. County medical societies are invited to designate competent members and this list is given to foremen for guidance when a surgeon is needed.

The Administration seeks to insure a fair and equal distribution of cases. It has no favorites. To accomplish

this impartial attitude each district compensation officer must keep and submit a cumulative report record of the number of injury cases treated by each doctor and the amount of each doctor's vouchers.

The Administration has had very few occasions for removing a doctor's name from the list of competent medical men. The chief cause for removal has been lack of cooperation in executing the paper work that is necessary and required by the Federal Commission.

Reports have come to us at rare intervals from individual doctors that their vouchers were disallowed. Investigation usually uncovers the following facts: The services rendered were not for a condition that resulted from employment or not received in the course of duty. A certain responsibility rests upon the doctor. He should know what cases and conditions are compensable. Knowing these, then, he should not charge his services to the Commission when the employee comes to him, even though the employee may present a WPA foreman's authorization for treatment for a cold. If doctors will become informed as to what constitutes compensable cases, there would be no difficulty regarding payment for services. The advice is to not expect compensation for services in cases and conditions not resulting from injury in the performance of duty.

Fees paid by the Federal Commission are not set up in any fixed schedule as far as medical services are concerned. The rule and precedent is to allow fees that are not in excess of the minimum charge in the community. The safe guide is to observe the fee schedule of the State Industrial Accident Commission.

The foregoing statements have been compiled from inquiries and investigations and are presented for the information of members.

COUNTY SECRETARIES' CONFERENCE

The annual conference of county secretaries was held in San Francisco on February 6.

The following secretaries, presidents, councilors, and state officers were present, numbering forty-seven:

STATE OFFICERS:

Edward M. Pallette, President
 Howard Morrow, President-Elect
 William W. Roblee, Speaker
 Morton R. Gibbons, Chairman of Council
 Karl L. Schaupp, Chairman of Executive Committee
 C. A. Dukes, Chairman of Committee on Public Relations
 Frederick C. Warnshuis, Secretary
 Calvert L. Emmons, Councilor
 A. E. Anderson, Councilor
 C. E. Schoff, Councilor
 Henry S. Rogers, Councilor
 T. Henshaw Kelly, Councilor
 J. B. Harris, Councilor
 Hartley F. Peart, General Counsel

COUNTY OFFICERS:

O. B. Doyle, Secretary, Fresno County Medical Society
 Merritt C. Canfield, Secretary, Imperial County Medical Society
 C. S. Compton, Secretary, Kern County Medical Society
 E. Vincent Askey, Secretary, Los Angeles County Medical Society
 S. K. Cochems, Executive Secretary, Los Angeles County Medical Society
 Carl W. Clark, Secretary, Marin County Medical Society
 A. L. Wessels, Secretary, Monterey County Medical Society
 F. D. Heegler, President, Napa County Medical Society
 Robert A. Peers, Secretary, Placer County Medical Society

*All articles listed under this caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

R. M. Wallerius, President, Sacramento Society for Medical Improvement
 Arthur E. Varden, Secretary, San Bernardino County Medical Society
 Willard H. Newman, Secretary, San Diego County Medical Society
 Stanley H. Mentzer, Secretary, San Francisco County Medical Society
 Charles R. Kennedy, President, San Luis Obispo County Medical Society
 E. D. Anderson, Secretary, San Luis Obispo County Medical Society
 J. Garwood Bridgman, Secretary, San Mateo County Medical Society
 William H. Eaton, Secretary, Santa Barbara County Medical Society
 R. S. Kneeshaw, President, Santa Clara County Medical Society
 Leslie B. Magoon, Secretary, Santa Clara County Medical Society
 Samuel B. Randall, Secretary, Santa Cruz County Medical Society
 John W. Green, Secretary, Solano County Medical Society
 C. M. Carlson, Secretary, Sonoma County Medical Society
 E. F. Hagedorn, Secretary, Stanislaus County Medical Society
 Karl F. Weiss, Secretary, Tulare County Medical Society
 A. A. Morrison, Secretary, Ventura County Medical Society
 Francis P. Wisner, from Yuba-Sutter County

COMMITTEE ON POSTGRADUATE INSTRUCTION:

C. G. Toland, Chairman
 John C. Ruddock
 Langley Porter
 Paul S. McKibbin

COMMITTEE ON PUBLIC POLICY AND LEGISLATION:

E. T. Remmen
 Ben H. Read, Public Health League
 W. R. P. Clark

The scheduled program was observed. The opinion was unanimous that the conference would be productive of desired results that would broaden as well as intensify county society activity.

AMENDMENTS TO THE CONSTITUTION

At the 1936 Coronado meeting two amendments were submitted to our Constitution. Under the rules they come up for consideration and action at our 1937 meeting in Del Monte.

Delegates are advised to study these amendments and be prepared to express the wishes of their county when called upon to vote. The amendments are as follows:

1. *To make the retiring president a member of the Council by creating the office of past president.*

Resolved, That Section 1 of Article VII of the Constitution of this Association be and is hereby amended by inserting in the first paragraph thereof after the words "the president" the following:

"The past president"; and be it further

Resolved, That Section 8 of Article VII of the Constitution of this Association be and is hereby amended by inserting after the words "the president" the following:

"The past president"; and be it further

Resolved, That Section 1 of Article X of the Constitution of this Association be and is hereby amended by inserting after the words "a president" the following:

"A past president"; and be it further

Resolved, That Section 2 of said Article X of the Constitution of this Association and the title thereto be amended to read as follows:

"Section 2. President-Elect, when and how elected; term of office. Past president.

"The House of Delegates at the regular annual session thereof shall elect the president-elect to serve until the adjournment of the final meeting of the House of Delegates at its next regular annual session. At the conclusion of the final meeting of the House of Delegates at its next regular annual session, such president-elect shall assume the office of president, and serve as such for the term of one year thereafter, or until his successor assumes office.

"At the expiration of his term of office the president shall become the past president and serve as such for a

term of one year thereafter, or until his successor assumes office"; and be it further

Resolved, That Section 4 of Article X of the Constitution of this Association be and is hereby amended by inserting in the first paragraph thereof after the word "president" the following:

"Past president."

2. *Limiting appropriation of funds by the House of Delegates.*

Resolved, That Section 1 of Article XI of the Constitution of this Association be and it is hereby amended as follows:

By striking out all of the fourth paragraph of said Section 1 of Article XI, reading as follows:

"All resolutions providing for appropriations shall be referred to the Council, and all appropriations approved by the Council shall be included in the annual budget."

And by inserting in lieu thereof the following: "Any resolution passed and adopted by the House of Delegates at any regular or special session thereof, which provides for or contemplates the appropriation or expenditure of more than the sum of \$1,000, shall not be effective for any purpose unless and until approved by the Council. All appropriations, regardless of amount, approved and made by the Council shall, if expended, be reported to the House of Delegates at its next annual session, and any unexpended portion of any thereof shall be included in the annual budget.

ILL-ADVISED RESOLUTIONS

Defined policies, their observance and unity as well as uniformity of action begets organizational influence and results. In brief, the "house united" not only stands, but also endures as well as achieves.

Our Association has, through the House of Delegates, established definite policies and directed the attitude and action to be demonstrated.

From time to time some group—national or state, some business firm or some social uplifters—will gain the public limelight by advancing suggestions for or initiating a proposed plan or movement. At first glance or consideration there may become manifest some sporadic endorsement. Such endorsers usually fail to give careful consideration to pertinent facts, they are unfamiliar with all the details, they neglect to inquire from dependable sources as to the standing of the sponsors and fail to ascertain from the American Medical Association or from their State Association the information that may be on hand.

The American Medical Association and our State Association's Council run down what is back of these movements and proposals, and as a rule have complete information at hand. Often this information discloses ulterior objectives that are adverse to the members' best interest.

Ever and anon the report comes in that this or that county, hospital, or group have gone on record by passing a resolution of endorsement, when, had all the facts been known, no such endorsement would have been voted.

County societies will do well to refrain from granting endorsements until the information available has been secured from Association headquarters. Subsequent embarrassment can be prevented by making such inquiry. Members are assured that the officers and Council are alert and that they set out immediately to acquire facts whenever panaceas and new plans are projected. It is advised that endorsement be held in abeyance until all the obtainable information has been secured. In these days be wary of all proposals that announce a specific for social and economic ills. Rackets and racketeers still exist and new ones spring up regularly. Certain persons, business houses, and publications still like to pose as the "saviors of medicine"—but for selfish profit first. Black sheep are not extinct.

DEL MONTE ANNUAL MEETING

The April issue will contain the official program and announcements to be held in Del Monte, May 2-6. Watch for it.

In the meantime write now for your hotel reservations to Mr. Carl Stanley, Manager, Hotel Del Monte. Mr. Stanley has entire charge of all hotel reservations in Monterey peninsula. Advise him as to what accommodations you desire. Your wishes will be met if it is at all possible. On January 20 over 750 reservations were on file. This need not cause dismay, as ample accommodations are

available in first-class hotels adjacent to the official headquarters.

An excellent program, distinguished out-of-state guests, unusual scientific exhibits and demonstrations, a large commercial exhibit, and a most delightful program of entertainment should induce you to attend. Yes, there will be golf and skeet shooting. Secure your reservations.

OFFICERS AND COMMITTEES

Nearly every week inquiries are received requesting names of chairmen of committees or president or secretary of some county society.

This information can be secured by consulting the front advertising section of any issue of this publication. In that front advertising section, several pages for years have been devoted to the listing of officers, committees, scientific sections, county societies, their officers and meeting dates and similar information. Attention is directed to these pages of official directory material.

PARAGRAPH REMINDERS

Copy these in your engagement book.

1. Pay county society dues before April 1—preferably today, so as to escape being placed on the suspended list.

2. File Federal income returns before March 15; State income report before April 15.

3. Write to Mr. Carl Stanley, Manager, Del Monte Hotel, Del Monte, today for hotel accommodations around Monterey Bay for annual meeting, May 2-6. Mr. Stanley is in charge of all reservations.

4. Write to State Secretary for legal protection secured by membership in the medical society of the State of California.

5. Read the advertising pages and patronize these advertisers.

6. Watch for the April issue, which will contain the annual program for the 1937 annual meeting.

7. Become acquainted with your senator and assemblymen and ask your county secretary how you can aid in defeating undesirable pending legislation.

8. Tell your patients and friends to listen in on radio medical programs. Program hours are listed in the News section of each issue.

9. Apply to State Secretary for American Medical Association fellowship application blank.

10. Take your colleague or friend who is a nonmember to your next county meeting and urge him to apply for membership if he is eligible and desirable.

Get out your pen and book and note these important items. Do not, please, pass them up.

ONE THOUSAND DOLLAR FEES

From now on, under rulings of the Treasury Department, individuals paying professional fees in excess of \$1,000 must report such payment to the income-tax collector. Apparently, Uncle Sam proposes to check up on the income of lawyers, physicians, dentists, or others who charge fees for services rendered.

The suggestion has been that these charges or fees be billed at \$999 in order to relieve the recipient of your services of the necessity of making the return on his income-tax statements. Uncle Sam may spend billions freely, but he also is becoming alert in collecting every tithe or pound of flesh due to him. Evasion or the making of false returns is severely penalized.

SKEET CONTEST

Skeet shooters are requested to send to Dr. Alfred Phillips of Santa Cruz their intentions to enter into the Skeet Contest on Tuesday afternoon of our annual meeting in Del Monte. It is quite important that Doctor Phillips has this information in order that he can perfect local arrangements. All who desire to enter this contest will please advise Doctor Phillips at once.

COUNCIL MINUTES

Minutes of the Two Hundred and Fiftieth Meeting of the Council of the California Medical Association*

Held in the Sir Francis Drake Hotel, San Francisco, Sunday, February 7, 1937, at 9:30 a. m.

The meeting was called to order by the chairman, Morton R. Gibbons, with the following members present:

President Edward M. Palette; President-Elect Howard Morrow; Speaker William W. Roblee; Chairman Morton R. Gibbons; Councilors Karl L. Schaupp, Calvert Emmons, Henry S. Rogers, Henry J. Ullmann, A. E. Anderson, Alfred L. Phillips, Harry H. Wilson, J. B. Harris, T. Henshaw Kelly; Chairman of Public Relations Committee Charles A. Dukes; Editor George H. Kress; Secretary F. C. Warnshuis; General Counsel Hartley F. Peart and his associate, Mr. Hassard.

Absent: Doctors Carl R. Howson, O. D. Hamlin, and William H. Kiger, on account of illness; and C. O. Tanner.

1. **Annual Meeting.**—The Secretary presented a report on the program for the annual meeting as outlined by the Committee on Scientific Work at its meeting on January 9, stating that the invited guests for general meetings would be Cyrus Sturgis, Ann Arbor, Norman Miller of the University of Michigan, and Doctor Bullowa of New York. Doctor Meleney of New York will appear on a Medical Section program.

Doctor Warnshuis stated that the Committee wished to conduct a general meeting on medical economics at the third general meeting, having as speakers, Doctors J. B. Harris, T. Henshaw Kelly, and D. Crosby, and one invited guest.

It was moved by Editor Kress, seconded by Councilor Anderson that Dr. William C. Woodward of the Bureau of Legislation and Legal Medicine of the American Medical Association be invited to participate in the program on medical economics. Carried.

2. **Supplement to California and Western Medicine.** Editor Kress called the attention of the Council to his correspondence with the Los Angeles and San Francisco postmasters relative to possible supplements to CALIFORNIA AND WESTERN MEDICINE, and suggested the desirability of printing the Pre-Convention Bulletin and annual session program in such a supplement. Thus, for April, there would be printed the regular number for that month, and also its supplement containing the regular annual session information.

Upon motion by Editor Kress, seconded by Councilor Phillips, it was voted to print such a supplement, the Secretary to contact the San Francisco post office authorities in regard to fulfillment of all postal regulations of that office in regard to supplements. Carried.

3. **Legislation.**—Junius B. Harris submitted a report on legislation stating that 3,879 bills had been introduced during the first session of the legislature, of which 256 contained matters of medical interest.

After discussion of correspondence presented by Dr. Henry Rogers, on motion of Chairman of Public Relations Committee Dukes, seconded by Editor Kress, the disposition and action on the entire matter was left to the judgment of the Legislative Committee. Carried.

4. **Intercoast Hospitalization Insurance Association.** The General Counsel submitted revisions prepared for inclusion in the rider attached to the policies of the Intercoast Hospitalization Insurance Company which would make it acceptable to the California Medical Association.

On motion of Councilor Schaupp, seconded by Councilor Ullmann, it was

Resolved, That the Council approve the amendment to the standard hospitalization policy of the Intercoast Hospitalization Insurance Association presented to the Council by the General Counsel at this meeting (a copy of said policy and of said amendments having been this day filed with the Secretary); and be it further

* The minutes of the two hundred and forty-ninth meeting of the Council of the California Medical Association were printed in the February, 1937, issue of CALIFORNIA AND WESTERN MEDICINE, page 120.

Resolved, That the approval heretofore given to said policy by the Council be rescinded in the event that on or before March 15, 1937, said amendments are not adopted and put into effect as to all policies to be thereafter issued by Intercoast Hospitalization Insurance Association, and that a resolution be not adopted by the Board of Directors of Intercoast Hospitalization Insurance Association that all policies heretofore issued by it be interpreted by it, as far as possible, in consonance with said amendments.

5. Medical Society of the State of California.—A letter from Councilor Carl Howson regarding the possibility of increasing membership in the medical society of the State of California was presented. It was the sense of the Council that there should be no direct solicitation of members.

6. Committee of Five.—Correspondence regarding the present status of the report of the Committee of Five was presented and discussed in detail.

It was moved by Councilor Wilson, seconded by Councilor Ullmann, that the following communication be sent to the Director of the State Board of Health, Walter M. Dickie:

Dr. Howard Morrow presented Doctor Sharp's letter of February 3, 1937, to the Council of the California Medical Association.

I am instructed by resolution of the Council to inform you that we are now in a position to bring about the publication of the medical economic survey in California. The program is to submit the material for condensation and deletion of personalities, together with the securing of other mature opinion regarding conclusions and recommendations, as advised by Mr. Stuart Rice.

The California Medical Association to have an informed representative to meet with Doctor Sharp, Doctor Dodd, and one from your department, regarding the scope of this work.

It will require approximately ninety days for completion. Thank you for your coöperation in this matter.

It was the sense of the Council that a letter be sent to Dr. Olin West, Secretary and General Manager of the American Medical Association, requesting that Doctor Leland be permitted to assist in the evaluation of the report of the Committee of Five.

The Committee of Five was instructed to go over the report preparatory to submitting it to Doctor Leland, and in the meantime the authority would be requested from the American Medical Association for Doctor Leland's evaluation of the report.

It was moved by President Pallette, seconded by Councilor Phillips, that Dr. Alson Kilgore be appointed as representative of the Council in the conference (requested by Doctor Sharp) with Doctor Sharp and the Board of Health in regard to the publication of the Medical-Economic Survey Report. Carried.

7. Committee on Survey of Expenditures.—William W. Roblee, member of the Committee on Survey of Expenditures, submitted the report of the Committee, which was read section by section.

On motion duly made, seconded and carried, the Chairman was instructed to appoint a Committee of Three to investigate and provide for termination of services of employees of the Association, and submit a report at the next meeting of the Council.

It was moved by Councilor Kelly, seconded by Councilor Anderson, that no expenditures should be made for legislation without the approval of the Chairman of the Committee on Public Policy and Legislation and the Chairman of the Auditing Committee. Carried.

It was moved by Editor Kress, seconded by Councilor Rogers, that a copy of the report of the Committee on Survey of Expenditures be sent to each member of the Council for his information. Carried.

The Council discussed the question of publication costs of the JOURNAL.

On motion of Editor Kress, seconded by Councilor Kelly, it was moved that the Chairman of the Council appoint a committee of three well-known printers to go over the cost sheets of CALIFORNIA AND WESTERN MEDICINE in the offices of the Barry Company and to make a report thereon to the Council. The Chairman of the Council to appoint the said committee of three printers, these

to be selected from well-known printing firms of San Francisco and Los Angeles. Also the Secretary and the Editor to prepare a set of specifications as to publication and distribution requirements of the official journal, and to present the same for consideration to the Council at its next meeting. Carried.

It was brought to the attention of the Council that no change in the policy of advertising matter on the JOURNAL front page could be made until the former action of the House of Delegates was again considered by that body.

It was moved by Councilor Ullmann, seconded by Councilor Wilson, that the report of the Committee on Survey of Expenditures, excepting those portions which were acted upon individually, be received and filed for future consideration. Carried.

8. Budget.—Karl L. Schaupp, Chairman of the Auditing Committee, presented the budget of the Association for the year 1937-1938.

Discussion was had of the allocation of dues of members to the JOURNAL, and on motion of President Pallette, seconded by Councilor Phillips, the previous action of the Council taken on September 7, 1935, allocating \$3 dues per member to the JOURNAL was reaffirmed. Carried.

It was moved by Councilor Kelly, seconded by Councilor Phillips, that the Council instruct our auditors to set up the books of the Association on a nonprofit basis. Carried.

It was the sense of the Council that the budget be referred to the Auditing Committee, who, with the auditors of the Association, shall make the necessary changes and resubmit the budget at the next meeting of the Council at Del Monte.

9. Recess.—At this point a recess of the Council was taken for luncheon.

10. Call to Order.—The Council was called to order by the Chairman, with the following members present: Doctors Pallette, Morrow, Roblee, Gibbons, Schaupp, Emmons, Ullmann, Anderson, Phillips, Rogers, Harris, Kelly, Dukes, Kress, Warnshuis, Mr. Hartley Peart, and Mr. Hassard.

11. Venereal Disease Control.—After full discussion of the campaign for venereal disease control and legislation in relation thereto, on motion of Councilor Kelly, seconded by Councilor Ullmann, it was

Resolved, That the Legislative Committee be instructed by the Council to support legislation for the control of venereal disease that is satisfactory in the judgment of the Committee and that is also supported by the State Board of Health.

12. San Diego Fair.—The Secretary stated that a moving picture had been prepared by Doctor Foord for use at the San Diego Fair at an expense of \$250 and that it had been impossible to use it on account of lack of sound apparatus. That the Chairman of the Exhibit Committee had advanced the cost from his personal funds. It was pointed out that it might be possible to dispose of the film to the American College of Surgeons or the American Society for the Control of Cancer.

It was moved by Councilor Ullmann, seconded by Councilor Kelly, that the Council authorize the payment of \$250. Carried.

13. Past Presidents.—It was moved by Councilor Kelly, seconded by Councilor Phillips, that the honorary certificate for past presidents as presented by the Secretary be approved and that one such certificate be presented to each living past president at the time of the Del Monte meeting, and a certificate be presented to each future retiring president. Carried.

14. Tuberculosis.—It was moved by Councilor Kelly, seconded by Councilor Schaupp, that the Secretary be authorized to take part in the symposium on publicity sponsored by the State Tuberculosis Association at its Riverside session. Carried.

15. Retired Memberships.—The Secretary presented membership data and requests for granting of retired memberships to members of the following county societies: Etta Farmer, Sacramento County; Charles Edward Hablutzel and Charles Shattinger, Santa Clara County; Marie A. Bennette and H. O. Beeson, San Bernardino

County; Sol Hyman and Mariana Bertola, San Francisco County.

It was moved by Councilor Kelly, seconded by Councilor Harris, that Etta Farmer, Sacramento; Charles Edward Shattinger, Charles Hablutzel, Santa Clara County; Sol Hyman and Mariana Bertola, San Francisco County, be granted retired membership in the California Medical Association. Carried.

It was moved by Editor Kress, seconded by Councilor Phillips, that the Secretary be instructed to present to the Council at its next regular meeting a report on possible amendments having to do with retired and honorary memberships. Carried.

16. Annual Session Reporting.—It was moved by Editor Kress, seconded by Councilor Schaupp, that the bid of the Yates Reporting Service for the annual meeting at Del Monte be accepted for one original and two carbon copies of minutes of the House of Delegates and general sessions.

17. Listing in Journal.—A request from a special society for publication of its name in the JOURNAL, under Miscellaneous Organizations, was presented and the limitations of space discussed.

It was moved by Chairman of Public Relations Committee Dukes, seconded by Councilor Ullmann, that the Council does not see its way clear to grant this listing at this time. Carried.

18. Hospital Standards.—After discussion of the question of standards of practice in certain hospitals, it was moved by Councilor Kelly, seconded by Councilors Ullmann and Emmons, that the Council of the California Medical Association does not approve attendance by members of component county societies in hospitals which permit other than doctors of medicine and dentistry licensed to practice in California to practice in the hospital. Carried.

19. Committee of Five.—It was moved by President Pallette, seconded by Councilor Rogers, that the Council rescind the action taken at its meeting on January 16, 1937, authorizing publication of 250 copies of the report of the Medical Economic Survey. Carried.

20. Date of Council Meeting.—It was moved by Councilor Schaupp, seconded by Councilor Phillips, that the next meeting of the Council be held at Del Monte, California, at 8 p. m., May 2, 1937.

21. Committee on Hospital and/or Medical Insurance.—T. Henshaw Kelly, Chairman of the Committee on Hospital and/or Medical Insurance gave a detailed report on amendments proposed by the dentists to the Association's bill for medical service, and other suggestions made for improvement of service offered by the bill.

It was moved by Councilor Ullmann, seconded by Editor Kress, that when amendments to the Association's medical service bill, and to the bill on hospital insurance are submitted by other interested parties, the Committee on Public Policy and Legislation and the Committee on Hospital and/or Medical Service Insurance be authorized to exercise its judgment as to the acceptance and support of such amendments. Carried.

22. Board of Health.—The question of personnel of the State Board of Health was discussed, and on motion of Editor Kress, duly seconded, the matter was referred to the Committee on Public Policy and Legislation. Carried.

23. Adjournment.—There being no further business, the meeting adjourned at 4:30 p. m.

MORTON R. GIBBONS, *Chairman.*
F. C. WARNSHUIS, *Secretary.*

Progress in medicine is progress in science, and progress in science is progress in civilization.

It is an old saying that chance comes only to the minds that are prepared to welcome it.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Legislation

As Dr. J. B. Harris, Chairman of the Committee on Legislation and Public Policy, stated at the Secretaries' Conference, the present session of the legislature would outdo all previous sessions in the number of bills and resolutions introduced. At the close of the first part of this session some 3,879 bills were filed. Some eight per cent, or 256 bills, are related or deal with health, medical practice and care, hospitals and health and hospital insurance.

An early tabulation indicates the purpose and form of proposed enactments.*

Supporting sound desirable legislation and opposing un-sound measures is not the sole duty or job of a chairman, committee, or officer. It is the duty and job of every one of our 5,500 members. Every county society and every member must enter into this legislative activity and respond to the directions and requests of our Committee on Legislation and Public Policy—the State Commanders. Members must not shirk, must not withhold action during the remainder of this legislative session.

It Is Happening Elsewhere

Wisconsin medical men find themselves in the throes of legislation that purposes to set up a system of insurance to provide medical and hospital care through compulsion. The present governor was elected, it is said, on that platform. It is reported that a "count of noses" indicates sufficient votes to pass such a law. Wisconsin will probably be the first state to enact this type of legislation, and as it is understood the medical profession will have no voice in control or direction. But a few years ago certain Wisconsin physicians were in a tirade and vocative expressions of disapproval because the California profession was confronted with a similar situation and condemned our Association and its officers because we were accused of inactivity. Compulsory health insurance laws are not on California's statute books. What is more, the Assembly Interim Committee on January 26, 1937, filed its report declaring "that the enactment of compulsory health insurance laws during the present session would be premature and ill-advised." The Committee recommended further study and report in 1939.

New Mexico is confronted with a situation similar to Wisconsin.

Minnesota finds the question a vital one during the present session of its legislature.

In Ohio, cultists are aggressive in an attempt to obtain broader regulations and recognition.

It is happening!

Medical and Legal Professions

The medical and legal professions have much in common. They have a joint relation to a large number of social and legislative movements and problems. On the other hand, there exists an interprofessional relationship and responsibility that has not been satisfactory at all times. Misunderstandings have frequently arisen mitigating against the welfare of members of both professions as well as the public.

The medical profession is well organized. The Bar Association functions for the legal profession. Both are representative and speak with authority for their professions. There exists, then, no good reason why these two organizations cannot, through designated representatives,

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

* EDITOR'S NOTE: See page 205 for list compiled by Committee on Legislation and Public Policy.

meet for the discussion of common interests, the adjustment of differences, the elimination of questionable practices, and the adoption of policies and procedures.

Such interchange of thought during prearranged meetings would accomplish desirable results and terminate differences. Salutory influences would become manifest.

To accomplish these ends it is hoped that some action will be taken at Del Monte that will bring about a series of meetings between the representatives of these two professions. The time is at hand when steps should be taken to obtain these ends.

Syphilis

Surgeon-General Parran has aroused nation-wide interest in a campaign for the reduction of the incidence of venereal infection—syphilis and gonorrhea. Publicity is increasing, and medical and lay groups are lining up in support of the movement. A warning was sounded by the Council when it adopted the following resolution:

Resolved, That the Legislative Committee be instructed by the Council to support legislation for the control of venereal disease that is satisfactory in the judgment of the committee and that is also supported by the State Board of Health.

This campaign, to be successful, must be fought out, as is any battle, under planned leadership—national, state, and county. Sporadic, independent and disassociated action should not be initiated in any community or region. All local activity should conform to the State plan and program adopted by the State Department of Health, with which department our Association is cooperating through a special committee, of which Dr. Howard Morrow is chairman.

COMPONENT COUNTY MEDICAL SOCIETIES

MARIN COUNTY

The Marin County Medical Society held its January meeting at the Marin Golf and Country Club. Dr. Anne Brady, the incoming president for 1937, was inducted into office.

Dr. Laurence R. Taussig gave a very interesting talk on *The Usual Skin Conditions as Met with by the General Practitioner*. The talk was illustrated by colored slides.

CARL W. CLARK, *Secretary*.



SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by President Raymond Wallerius at the auditorium on Twenty-eighth and L streets on January 26. There were thirty-eight members and guests present.

The scheduled speaker of the evening, Dr. R. G. Leland, was unable to attend. In his absence, Mr. A. F. Henning, managing director of the local Retail Credit Association, gave an interesting talk on the *Economics of Credit*. Mr. Henning stated that there are about 400,000 credit cards on file at the Association; that 60,000 claims have been filed by professional men in the past ten years, of which 49.8 per cent were salvaged. The elimination of credit waste is the main endeavor of the Retail Credit Association, he said. The paper brought forth considerable discussion by the members.

A report on the passing of Dr. A. K. Dunlap was read by Dr. F. Scatena. A resolution was passed that the report be placed on the minutes of the Society and a copy be sent to the widow.

Doctor Soutar gave a report on the prevalence of influenza among school children, and asked that physicians report any cases found in their practice.

Doctor Turner discussed the matter of fees for testimony in legal cases, and stressed the fact that many physicians are not collecting for these services as they should. He also advised that the Board of Directors adopt a new fee schedule at their next meeting if possible.

Doctor Cook gave a report on the results of tuberculin testing in the city schools. Of the 1,297 students tested

at the high school, 358 (30 per cent) were found to be positive. Five of the adult type of active tuberculosis were found.

G. E. MILLAR, *Secretary*.



SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held in the Medico-Dental clubrooms on January 7 at 8:30 p. m. The meeting was called to order by Vice-President A. L. Van Meter.

Preceding the regular meeting the customary supper meeting was held at the Hotel Wolf, at which fifteen members and guests were present. The paper at the supper meeting was given by Dr. G. H. Rohrbacher, who spoke on the *Battle of Gettysburg*.

The regular meeting was opened by Dr. C. A. Broadus, talking on the work of the Postgraduate Committee and their plans for the future.

Vice-President A. L. Van Meter installed President-Elect Dr. J. F. Blinn, who carried the meeting on from this point.

Doctor Hull brought up the question of a meeting between the Medico-Dental Society and the San Joaquin County Medical Society on the evening of January 25, on the occasion of Doctor Leland's visit to us. This was discussed by several members from the floor, and Doctor Broadus made a motion, seconded by Doctor Collis, that there be a joint meeting held on the above date.

Doctor Chapman spoke of the desirability of contacting the legislators at Sacramento from this district to try to impart to them our opinions of impending legislation. Doctor Sanderson made a motion, seconded by Doctor Collis, that a committee be appointed to plan ways and means for this contacting. The motion was carried. Doctor Chapman was appointed chairman of this committee, the committee to be announced later.

Doctors Van Meter and Sanderson spoke in favor of the \$5 a year increase of dues that the California Medical Association has instituted.

The petition of Doctor Hidy of Manteca having been accepted by the Committee on Admissions and there being no opposition from the floor, Doctor Hidy was elected a member. The petition for transfer of Dr. Paul A. Werthmann was received and read. There being no opposition from the floor, Doctor Werthmann was elected a member. Petitions for membership were received from Dr. T. C. Russell of Tracy, Dr. E. S. Leavenworth of Brentwood, Dr. Oliver Riggle of Lodi, Dr. Paul R. Shumaker and Dr. W. G. Patton, both of Stockton, were received and read. These petitions were referred to the Committee on Admissions for approval and recommendations.

A motion was made by Doctor Broadus, seconded by Doctor Van Meter, that potted plants be sent Doctors Thomas O'Connor and Kaplan, also letters of sympathy regarding their sickness. The motion carried.

The scientific program was given by Doctor Vieira, who announced that Dr. O. W. Jones of San Francisco was sick with influenza and would be unable to present his paper. Dr. Howard Brown of the University of California talked on *Spinal-Cord Tumors*. This talk was well received and caused considerable comment.

There being no further business to come before the Society, the meeting was declared adjourned at 10:30 o'clock and refreshments were served.



The regular meeting of the San Joaquin County Medical Society was held in the Roof Garden of the Hotel Wolf, Stockton, February 4, President John F. Blinn presiding.

The regular session was preceded by the customary supper meeting, at which fifteen members were present.

The paper at the supper meeting was given by Dr. G. H. Rohrbacher, who gave a demonstration of the modern medical equipment as used by the Army and National Guard. The regular meeting was called to order at 8:30 p. m.

The application of Dr. Elliott P. Smart from the Los Angeles County Medical Society for affiliation with this Society was presented to the members and approved.

Dr. H. S. Chapman reported on the progress of his committee which was to contact the legislators of northern California relative to health legislation.

Dr. C. A. Broadbudd made a motion, seconded by Doctor Van Meter, that the change in the by-laws relative to suspending members as requested by the California Medical Association, be referred to the directors for consideration, and their recommendations followed.

Dr. Dewey Powell made a motion, seconded by Doctor Van Meter, that the following resolution concerning the death of Dr. Thomas C. O'Connor be spread upon the minutes and a copy be sent to his widow. The motion carried.

IN MEMORIAM: THOMAS C. O'CONNOR, JR.

The members of the San Joaquin County Medical Society were shocked and grieved to learn on the thirteenth day of January, 1937, of the tragic death of their immediate past president, Dr. Thomas C. O'Connor, Jr.

Doctor O'Connor was born in Stonington, Connecticut, on the fifteenth day of August, 1893. His pre-medical education was obtained at the University of Nevada. He was graduated in medicine from the University of California Medical School on the eleventh day of May, 1927, and was licensed to practice in this State in December of that same year. He was junior assistant of the Colfax School for Tuberculosis until 1929, at which time he accepted the position of medical superintendent of Bret Harte Sanatorium. He resigned from that post in the autumn of 1936, and was preparing to enter private practice in his specialty of chest diseases in the city of Oakland at the time of his death.

The members of this Society esteemed Doctor O'Connor very highly for his professional attainments. His counsel was sought and valued in the problems of diagnosis and treatment of chest diseases, and his ability as a director and administrator is best evidenced by the fine results that have been achieved and the present standing attained by Bret Harte Sanatorium. His enthusiasm for his work and his loyalty to organized medicine was best manifested by the many long trips he took to attend our meetings, to serve on committees and the Board of Directors, and by the efficient manner by which he presided over our deliberations during 1936.

Doctor O'Connor has left a lasting impression with his coworkers and friends, and we desire to herewith extend to his widow and daughter our sincere sympathy and to also have a copy of this resolution spread in full upon the minutes.

Doctor Hull made a motion, seconded by Doctor English, that a copy of this resolution be sent to the editors of each paper in this county. Motion carried.

The papers of the evening were submitted by Dr. Harold P. Hill, who spoke on *Influenza and Influenza Pneumonia*. A second paper was read by Dr. Charles W. Barnett of Stanford University, who substituted for Dr. Russell V. Lee, on *Control of Venereal Infection*. Both papers caused considerable comment.

President Blinn suggested that all those who had not contributed to the flood relief, place their contribution in the box on the table.

G. H. ROHRBACHER, *Secretary*.



TULARE COUNTY

The January meeting of the Tulare County Medical Society was devoted to business matters and the annual election of officers.

Dr. J. C. McClure, President, presided at dinner. There were present Doctors Guido, Rosson, Ginsburg, Preston, Parkinson, Wynn, Austin Miller, Weiss, McClure, A. E. Anderson, Fillmore, Lipson, Falk, Hill, Mathias, and Brigham.

District Councilor A. E. Anderson of Fresno discussed the proposed voluntary health insurance measure and read the proposed code which the councilors are to pass on.

A general résumé of the Society's activities for the year 1936 was given.

Local Society dues were voted to remain the same as in the past, thus making a total of \$25 for State and local societies.

The application of Dr. Lynn Smith of Springfield was read and he was unanimously elected to membership.

Election of officers for the year 1937 resulted as follows: Dr. R. C. Hill of Exeter, president; Dr. Austin Miller of

Porterville, vice-president; Dr. K. F. Weiss of Visalia, secretary-treasurer; Dr. Ray Rosson of Tulare, censor, 1940; Dr. J. C. McClure of Lindsay, delegate; Doctor Parkinson of Tulare, alternate.

KARL F. WEISS, *Secretary*.



VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the Ventura Country Club on Tuesday, November 10, 1936, at 7 p. m.

Members present were: Doctors Shore, D. G. Clark, Strong, Drace, Barker, Hendricks, Osborn, Bardill, Gronhøvd, Mosher, and Morrison. Guests were: Doctors Ullmann and Moffat.

Doctor Ullmann spoke briefly on the impending state legislation, stressing particularly hospital insurance and the necessity for immediate action. Doctor Ullmann suggested that we appoint legislative and insurance committees.

Dr. D. G. Clark introduced Doctor Moffat of Santa Barbara, who presented a paper on *A Patient with Extreme Obesity, Amenorrhea, Hypertension, and Diabetes* (case report). The patient was successfully treated with anterior pituitary sex hormones.

Business meeting followed.

Announcement was made of a postgraduate course to be given by the College of Medical Evangelists in Los Angeles. A similar announcement was made in regard to the College of Heart Symposium in San Francisco.

The State Secretary's monthly letter was read.

The first reading of the amendment for disciplinary procedure was given by the secretary.

Dr. D. G. Clark made a motion, seconded by Dr. H. E. Barker, that we approve the Alameda County Hospital insurance plan. The motion was unanimously carried. The secretary was instructed to write a letter to secure data on the above plan.



The Ventura County Medical Society held its annual banquet and election of officers at the Saticoy Country Club on Tuesday, December 8, 1936.

Members present were: Doctors Shore, Coffey, Mosher, Gronhøvd, Armitstead, Felberbaum, S. Clark, C. Smolt, Barker, Homer, and Strong. Guests were: Dr. Dan Clark of Santa Barbara, Doctor Cashew of Carpinteria, Mr. Charles A. Son and Mr. Gallagher of the Industrial Accident Commission.

Following the dinner the meeting was called to order by President Shore.

Mr. Charles A. Son gave a talk on the relationship between the Industrial Accident Commission and the medical profession.

Resolutions regarding the unfair practices of the public health nurses in the handling of school children, and one condemning the inadequate facilities for the proper care of smears and cultures in the outlying districts, were sent to the County Health Officer. A copy of the latter resolution was also sent to the Board of Supervisors.

Discussion was held in regard to establishing a minimum fee schedule for the county. No definite action was taken in regard to this measure.

Discussion was held in regard to the vaccination of children in the Ventura schools. Since this was a local problem, it was decided to let the physicians of that community reach their own solution.

A second reading of the amendment for disciplinary procedure was given by the secretary.

The following officers were unanimously elected for the coming year: Dr. F. R. Hendricks of Ventura, president; Dr. G. C. Drace of Ojai, vice-president; Dr. A. A. Morrison of Santa Paula, secretary-treasurer; Dr. G. C. Coffey of Ventura, delegate.



The Ventura County Medical Society held its regular monthly meeting at the Saticoy Country Club on Tuesday, January 12.

Members present were: Doctors Hendricks, Bardill, Shore, Drace, Barker, Mosher, D. G. Clark, Gronhøvd, Coffey, and Morrison. Guest: Doctor Eckhardt.

Following the dinner the meeting was called to order by President Hendricks.

President Hendricks read a résumé of the tentative bill to be sponsored by the California Medical Association. Doctor Coffey made a motion, seconded by Dr. D. G. Clark, that we go on record favoring such an insurance plan to be sponsored by the California Medical Association. The motion carried. Doctor Shore suggested that this insurance be limited to the lower income groups.

Doctor Bardill made a motion, seconded by Doctor Shore, that members sending in cards and not attending the meeting were to be assessed \$1, unless the secretary is notified by five o'clock the preceding day. The motion carried.

A third reading of the amendment for disciplinary procedure was given by the secretary. Doctor Coffey made a motion, seconded by Dr. D. G. Clark, that the amendment be adopted. The motion carried.

Doctor Mosher made a motion, seconded by Doctor Barker, that we endorse the Roche plan of medical advertising through the American Medical Association.

Doctor Shore made a motion that Doctor Porter be accepted for immediate membership. The motion was seconded and carried.

The secretary was instructed to write letters to Doctor Homer and Doctor Illick, who are ill.

Doctor Shore is in charge of the program for February.

A. A. MORRISON, *Secretary*.

CHANGES IN MEMBERSHIP

New Members (42)

Alameda County.—George A. Bakke, David R. Hadden, George S. Irvine.

Fresno County.—Hugh Awtrey, D. H. Trowbridge, Jr. *Imperial County*.—T. T. Mitchell.

Lassen-Plumas-Modoc County.—John W. Moore.

Los Angeles County.—Ralph W. Avery, Grant Beckstrand, P. Conrad Casper, E. L. Christeson, Erle Henriksen, Phillip Levine, M. H. Nathanson, Charles H. Pettet, Helen E. Preston, Samuel J. Sills, Walter H. Wieman.

Merced County.—E. M. Soderstrom.

Orange County.—Luther C. Davison, John J. Montanus.

Sacramento County.—W. F. Lowe.

San Bernardino County.—Ernest Cadwell.

San Diego County.—Leonard C. Fry, Thomas S. Mooney, Clarence E. Nelson, Thomas S. O'Connell, James E. Reeves.

San Francisco County.—Lazarre John Courtright, Burt L. Davis, Jr., John A. Driscoll, John B. Fershtand, Elliot G. Schneider, Steven Frederick Slepnikoff, Kazue Togsaki, Teru Togsaki.

San Joaquin County.—E. A. Anderson.

San Luis Obispo County.—Henry Fenno Sawtelle.

Santa Barbara County.—Walter Marius Anderson, C. W. Henderson, P. F. Munch.

Transferred (4)

Edward W. Bulley, from San Mateo County to Merced County.

Sophie M. Loven, from San Francisco County to Kern County.

Marshall E. Porter, from Sonoma County to Ventura County.

Thomas A. Wong, from San Francisco County to Los Angeles County.

Resigned (5)

Jessie M. Bierman, from San Francisco County.

Herbert M. Every, from Sonoma County.

Mark Gerstle, Jr., from San Francisco County.

Asher D. Havenhill, from San Francisco County.

Thomas H. McGavack, from San Francisco County.

In Memoriam

Carey, Henry Benjamin. Died at San Francisco, February 4, 1937, age 61. Graduate of the Northwestern University Medical School, Chicago, 1905. Licensed in California in 1906. Doctor Carey was a member of the San Francisco County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Denman, Claire H. Died at Berkeley, January 12, 1937, age 69. Graduate of Hahnemann Medical College and Hospital of Philadelphia, 1893. Licensed in California in 1907. Doctor Denman was a member of the Alameda County Medical Association, the California Medical Association, and the American Medical Association.

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Dunlap, Albert Knight. Died at Sacramento January 19, 1937, age 47. Graduate of Jefferson Medical College of Philadelphia, 1916. Licensed in California in 1917. Doctor Dunlap was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

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Ghrist, David Garrison. Died at Los Angeles, February 3, 1937, age 38. Graduate of Harvard University Medical School, Boston, 1925. Licensed in California in 1926. Doctor Ghrist was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Lenker, Walter Dora. Died at San Bernardino, January 30, 1937, age 43. Graduate of the College of Medical Evangelists, Loma Linda, 1918, and licensed in California the same year. Doctor Lenker was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Minaker, Andrew J. Died at San Francisco, January 16, 1937, age 60. Graduate of the Hahnemann Medical College of the Pacific, San Francisco, 1899, and licensed in California the same year. Doctor Minaker was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Renz, Carl. Died at Mill Valley, January 22, 1937, age 73. Graduate of the University of Tübingen, Tübingen, Germany, 1889. Licensed in California in 1893. Doctor Renz was a retired member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Sweet, Frank Dumont. Died at Long Beach, January 24, 1937, age 50. Graduate of Emory University School of Medicine, Atlanta, 1916. Licensed in California in 1917. Doctor Sweet was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

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Van Sickle, J. Russell. Died at Santa Monica, January 16, 1937, age 57. Graduate of Wayne University College of Medicine, Detroit, 1906. Licensed in California in 1925. Doctor Van Sickle was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

OBITUARY

Thomas C. O'Connor, Jr.

WHEREAS, Thomas C. O'Connor, Jr., was one of our early and most valued members; and

WHEREAS, His untimely death has severed a close and valuable personal friendship as well as deprived us, individually and severally, of a sympathetic and genuinely scientific point of view toward the problems of the patient with tuberculosis; therefore be it

Resolved, That the Laennec Society of Northern California adjourn this regular meeting out of respect to his memory; and be it further

Resolved, That a copy of this resolution be spread upon the minutes and notice thereof sent to his family.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

State Board Meeting

The State Board met at the Hotel Leamington in Oakland Wednesday, February 10. The meeting was called to order by the president, Mrs. Andrew J. Thornton of San Diego. The following Board members answered to roll call: San Diego, Mrs. Willard Newman; Los Angeles, Mrs. Clifford A. Wright, Mrs. John V. Barrow, Mrs. Benjamin H. Sherman, Mrs. Mark Albert Glaser, and Mrs. Arthur J. Annis; San Jose, Mrs. John Hunt Shephard; San Francisco, Mrs. George H. Becker and Mrs. Frank H. Rodin; San Rafael, Mrs. Robert M. Furlong and Mrs. Harry O. Hund; Oakland, Mrs. Frank R. Makinson, Mrs. Hobart Rogers, and Mrs. Charles C. Hall.

Six county presidents were present: Mrs. F. J. Maggs of San Joaquin, Mrs. Charles Moore of Santa Clara, Mrs. J. C. Geiger of San Francisco, Mrs. F. C. Knox of Monterey, Mrs. C. W. Page of Alameda, and Mrs. Harry O. Hund of Marin.

Since last Board meeting, Monterey County has organized, and much interest and enthusiasm was reported. They are coöperating with the convention chairman, Mrs. John Hunt Shephard, in making the annual meeting a most enjoyable one. A record attendance is expected at the Del Monte meeting. Splendid reports were given by the chairmen of the different departments and the councilors.

At one o'clock a delightful social hour and luncheon was enjoyed in the Peacock Room of the Leamington Hotel. The luncheon table was beautifully decorated in spring flowers.

Following the afternoon session a tea was given at the home of Mrs. Charles C. Hall honoring the president, Mrs. Charles A. Dukes, a past president of Alameda County, and Mrs. Thomas J. Clark, Jr., past president of the State Auxiliary, presided at the tea table. Assisting in the dining room were members of the Alameda County Board of Directors, including Mrs. Frank Baxter, Mrs. T. Floyd Bell, Mrs. Helen Gleason, and Mrs. W. O. Solomon.

Component Auxiliaries

Alameda County

The January luncheon meeting of the Woman's Auxiliary to the Alameda County Medical Association was held at the Claremont Country Club on January 15.

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Robert M. Furlong, chairman of the Publicity and Publications Committee, Linden Lane, San Rafael. Brief reports of county auxiliary meetings will be welcomed by Mrs. Furlong and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

Mrs. W. H. Sargent, past president of the State Auxiliary, as well as of the Alameda County Auxiliary, was the hostess of the day, and the decorations were in charge of a committee headed by Mrs. T. F. Bell.

The chief items of business were the presentation of the handbook for the new year and an announcement concerning the loan fund for medical students.

The handbook contains a brief history of the Association, a complete membership roster, and the recently amended constitution. It should prove a practical aid to the members in their work.

Letters from both the University of California and Stanford Medical Schools were read, acknowledging the receipt of the loan funds for this year. One has already been granted to a student, and the other is in process of allocation.

The speaker of the day, Dr. Mary Burch of Mills College, gave an interesting talk on *The Problems of Childhood*. Doctor Burch is a specialist in child guidance, so had much that was interesting to tell.

It was announced that at the February 12 luncheon the guest of honor and speaker would be Mrs. A. J. Thornton, President of the State Auxiliary.



Los Angeles County

The Woman's Auxiliary to the Los Angeles County Medical Association met at the Orthopedic Hospital on Tuesday, January 26, with 110 members present. The attractive table decorations of pansies and ferns proved the ingenuity of the capable Flower Committee chairman, Mrs. William M. Daniel, in this period of frozen gardens.

As the program was of particular interest and along the line of public thought in connection with the significance of the President's Ball, quite a number of guests attended.

Dr. Robert L. Carroll, orthopedic surgeon, gave a talk on infantile paralysis.

A demonstration of rehabilitation of handicapped children was given by presentation of a play by crippled children of the Orthopedic Hospital. Trained to emphasize the value of the voice rather than body action, these young actors performed so convincingly, though confined in wheel chairs, braces or casts, that they gave almost the feeling of normal motion without actually moving around the stage.

The Auxiliary voted to contribute \$25 to the Red Cross for relief of flood victims in the Middle West.

MRS. ROBERT L. CARROLL, *Chairman of Publicity*.



Marin County

The Woman's Auxiliary to the Marin County Medical Society was addressed on Thursday evening, January 28, at the Marin Golf and Country Club by Mr. Harry Sapper of Oakland on the subject of *Social Education and Progress*.

At a tea given at her home on Grand Avenue recently, Mrs. Harry O. Hund, president of the Marin County Auxiliary, was hostess to the doctors' wives of Marin and Sonoma counties.



Monterey County

It is with great pleasure we announce that Monterey has joined the ranks of the Woman's Auxiliary to the California Medical Association.

The first meeting was held in January at the home of Mrs. Garth Parker of Salinas. Officers were elected and plans made for the new Auxiliary.

Mrs. John Shephard of Santa Clara was guest speaker. Her talk helped us greatly, for we were anxious to know how we could be of service to our community and not merely a social organization, and Mrs. Shephard pointed out many ways in which we could definitely be of help.

The matter of greatest importance at the moment is the Del Monte convention in May. This gives us something definite to work for, in which we are all interested.

We hope to have Mrs. Andrew J. Thornton with us at our February meeting to discuss the convention plans.

The following list contains names of charter members and officers: Mrs. Lawrence Knox of Carmel, president; Mrs. Arthur Wessels of Salinas, vice-president; Mrs. John Gratiot of Pacific Grove, secretary; Mrs. W. H. Farr of Salinas, treasurer.

Mesdames A. A. Arehart, Raymond Rukke, J. P. Sandholt, Mast Wolfson, Monterey; L. P. Daylin, Gonzales; William Gratiot, H. Spencer Hoyt, Winton Swengel, Pacific Grove; R. O. Griess, James McPharlin, Werner Meyenberg, Garth Parker, L. E. Smith, Mrs. F. E. Wiebe, Salinas.

RUTH RHODES GRATIOT, *Secretary*.

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Orange County

The regular meeting of the Woman's Auxiliary to the Orange County Medical Association for February took the form of a luncheon meeting at Danigers Tea Room in Santa Ana on February 2. Twenty-five members were present. The meeting was the first "no host" one of this year, and a discussion was held as to whether to make all the meetings luncheon or not, but no decision was made.

Mrs. L. E. Wilson, a member of the Public Health Committee, spoke briefly on the *Social Security Act*.

A scholarship loan for medical students of Orange County was established to be taken care of through our local junior college.

No other important business was discussed.

The program was a book review by Mrs. Hiram Currey, one of our members, who reviewed Victor Heiser's *An American Doctor's Odyssey*.

MRS. EDW. LEE RUSSELL, *Publicity Chairman*.

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San Diego County

The regular luncheon meeting of the Woman's Auxiliary to the San Diego County Medical Society was held at the University Club. The president, Mrs. F. G. Lindemulder, presided.

Mrs. Elmo Crabtree made another appeal for *Hygeia* subscriptions.

Our honorary member, Dr. Frances P. Elliott, was introduced and she very graciously acknowledged the introduction.

Mrs. Gage Wetherell, Chairman of the Social Committee, announced that, in order to raise funds, six benefit bridge teas will be given February 9 at the homes of Mesdames Elliott Colby, R. Emerson Bond, Alex Lesem, Thomas Whitelock, Jr., R. H. Lundberg, and F. G. Lindemulder.

Mrs. E. H. Christopherson, Chairman of the Public Relations Committee, told of plans for the Health Education program to be given Wednesday, February 24, at the Y. W. C. A. The general subject of this meeting will be *What Is New in Medicine*.

March of Medicine was given in a one-minute report by Mrs. H. W. Dickerson and a five-minute report by Mrs. R. Emerson Bond.

Our state president, Mrs. A. J. Thornton, guest speaker of the day, gave us a brief history of the Woman's Auxiliary, encouraging us in our local and state work.

Mrs. Thornton's talk was followed by an amusing greeting from Mrs. Willard Newman, State Corresponding Secretary.

Meeting adjourned.

ELIZABETH R. BELFORD, *Secretary*.

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Santa Barbara County

The Woman's Auxiliary to the Santa Barbara County Medical Society held its January meeting on the 18th at the home of Mrs. Henry J. Profant in Mission Canyon.

The meeting was preceded by a delightful luncheon served buffet style. Twenty-four members were present. Five ladies from Santa Maria were a welcome addition

to our group, this being the first time that members from the northern part of the county have attended one of our meetings. Mrs. N. N. Brown, District Councilor, was to have attended the meeting, but was detained on account of illness.

Mrs. C. T. Roome, one of the judges of the Essay Contest, reported on the results of the contest. Five essays on *Immunization: Its Theory, Practice, and Results*, were sent in from the high schools and colleges of the county. First prizes of \$20 each went to Earl O. Homan of the State College and Doris White of the Santa Barbara High School. Second prize went to Norma Pratt, and third to Daniel Scher, both of the State College. The second prize was \$10 and the third \$5, and all of them will be awarded soon at assemblies in the respective schools.

It was decided that we would, as usual, give a prize of \$10 to the best all-round nurse in the graduating class of the Cottage Hospital, the prize to be given at the graduating exercises on January 29. Plans were discussed for the annual benefit bridge party, and it was decided to set the date immediately after Easter.

Mrs. Roome read the essay which won the first prize, which described in about 1,500 words the two theories of immunization as offered by Erhlich and Metchnikoff. This was followed by a brief history of vaccination and a review of the results as applied chiefly to smallpox. All were agreed that Earl Homan deserved the prize he had won, and it is expected that following the publicity of the awarding, more essays will be submitted another year.

MRS. H. E. HENDERSON.

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Santa Clara County

Report of the regular meeting of the Woman's Auxiliary to the Santa Clara County Medical Association.

The meeting was a luncheon held at the San Jose Country Club on February 8, forty-two members being present.

Honored guests and speakers were Mrs. Andrew J. Thornton, state president, and Mrs. Willard H. Newman, state corresponding secretary of San Diego. Mrs. Thornton painted a verbal picture of the history and organization of the medical auxiliaries, and stressed the importance of a well-functioning social and educational group.

A letter was read from the American Association of University Women inviting members of the Auxiliary to hear Dr. Leo Eloesser of San Francisco, recently returned from a three months' stay in Russia, speaking on *Medical Education, Care and Organization in the Soviet Union*.

Mrs. Charles E. Moore, president, announced March 6 was selected by the Auxiliary committee for an informal dinner dance to be held at the San Jose Country Club for members and their husbands.

Mrs. John Hunt Shephard, chairman of the State Auxiliary convention to be held at Del Monte in May, urged all members to take an active part in the various committees.

MRS. DANIEL BILKER, *Publicity Chairman*.

Treatment of Intestinal Toxemia with Castor Oil.—Schoenbaum and Moomaw show that the colon is the principal focus of infection in toxemia and should receive at least as much attention as the teeth, tonsils, and other structures. Many constitutional disturbances as well as those of the abdominal cavity have their origin in a toxic condition of the enteric tract. In this connection the author mentions nervous, hepatic, biliary, circulatory and respiratory disorders, anemias, rheumatism, arthritis, disorders of the skin, backache, and other disturbances. He says that the so-called normal flora of the intestinal canal may assume pathologic activities under favorable conditions. The colon bacillus is the agent most frequently responsible for nongonorrheal infections of the genito-urinary system. Measures aimed at the detoxification of a septic colon will often help in solving a difficult diagnostic problem. The theory of intestinal toxemia is supported by clinical experience. In discussing the treatment, the author presents evidence on the detoxifying effect of castor oil and its conversion product, sodium ricinoleate.—*Virginia Medical Monthly*.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 7-11. Olin West, M.D., 535 North Dearborn Street, Chicago, secretary.

California Medical Association, Del Monte, May 3-6. F. C. Warnhuis, M. D., 450 Sutter Street, San Francisco, secretary.

Medical Broadcasts*

American Medical Association

The American Medical Association and the National Broadcasting Company are presenting the second series of dramatized health broadcasts, under the title, "Your Health." The first broadcast in the new series, the thirty-second dramatized cooperative broadcast under the title "Your Health," was given October 13, 1936. The theme for 1936-1937 differs slightly from the topic in the first series, which was "Medical Emergencies and How They Are Met." The new series is built around the central idea that "one hundred thousand American physicians in great cities and tiny villages, who are members of the American Medical Association and of county and state medical societies, stand ready, day and night, to serve the American people in sickness and in health."

The program will be on the Blue network instead of the Red, as originally announced.

The topics are announced monthly in advance in *Hygeia*, the health magazine, and three weeks in advance in each issue of the *Journal of the American Medical Association*.

The time of the broadcast is Tuesday afternoon, two o'clock, Pacific time.

San Francisco County Medical Society

A radio broadcast program for the San Francisco County Medical Society for the month of March is as follows:

Tuesday, March 2—KYA, 6 p. m.
Tuesday, March 9—KYA, 6 p. m.
Tuesday, March 16—KYA, 6 p. m.
Tuesday, March 23—KYA, 6 p. m.
Tuesday, March 30—KYA, 6 p. m.

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of March is as follows:

Tuesday, March 2—KECA, 10:30 a. m., The Road to Health.
Saturday, March 6—KFI, 9:15 a. m., The Road to Health.
Saturday, March 6—KFAC, 10:15 a. m., Your Doctor and You.
Tuesday, March 9—KECA, 10:30 a. m., The Road to Health.
Saturday, March 13—KFI, 9:15 a. m., The Road to Health.
Saturday, March 13—KFAC, 10:15 a. m., Your Doctor and You.
Tuesday, March 16—KECA, 10:30 a. m., The Road to Health.
Saturday, March 20—KFI, 9:15 a. m., The Road to Health.
Saturday, March 20—KFAC, 10:15 a. m., Your Doctor and You.
Tuesday, March 23—KECA, 10:30 a. m., The Road to Health.
Saturday, March 27—KFI, 9:15 a. m., The Road to Health.
Saturday, March 27—KFAC, 10:15 a. m., Your Doctor and You.
Tuesday, March 30—KECA, 10:30 a. m., The Road to Health.

*County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Cancer Commission Pathology Conference.—The annual pathological conference, given under the sponsorship of the Cancer Commission of the California Medical Association, will be held at the Del Monte Hotel, Del Monte, on Sunday, May 2.

The program will include a full morning and afternoon session. The plan at present is to present short symposia upon various groups of tumors, with interesting cases interspersed through the meeting. It is hoped that reports on tumors exhibited at former sessions will be made.

All those desiring to present cases and slides are requested to return the same to the chairman of the committee, Dr. Z. E. Bolin, 490 Post Street, San Francisco, at their earliest convenience, accompanied by one hundred slides and a case history which is to be mimeographed. Those who wish to participate in the conference are requested to register with chairman of the committee as soon as possible.

As in previous sessions, there will be no provision made for microscopes. Please bring your own microscope.

Annual Meeting of the California Tuberculosis Association.—A symposium on silicosis by three visiting speakers will be presented at the opening session of the annual meeting of the California Tuberculosis Association at Riverside, April 2 and 3.

Dr. Leroy U. Gardner, Director, Saranac Laboratory for the Study of Tuberculosis, Saranac Lake, New York, Dr. R. R. Sayers, United States Public Health Service, Washington, D. C., and Dr. Anthony J. Lanza, Assistant Medical Director of the Metropolitan Life Insurance Company, New York, will conduct the symposium. These sessions will be held on Friday morning, April 2.

A clinical session will be held Friday afternoon, at which time there will be papers presented as follows: "Bronchial Stenosis," Dr. Leo Eloesser; "Pneumoperitoneum," Dr. Harold Trimble and Dr. Buford Wardrip; "Bilateral Pneumothorax," Dr. Everett Morris.

On Saturday morning a second clinical session will be held. Papers will be presented on "Relationship of Trauma to Tuberculosis," by Dr. Munford Smith, and "Diagnoses of Tuberculosis of the Intestinal Tract" and "Differential Diagnosis of Diseases of the Chest."

On Friday afternoon there will be a sociological session with a paper on "Epidemiology of Tuberculosis," presented by Dr. Reginald Smart of Los Angeles, and a presentation of the problem of "Tuberculin Testing of High School Students" from the viewpoint of the medical profession, the health officer, the school administration, school physician, and the public health nurse.

A second sociological session will be held on Saturday morning, at which there will be a discussion of "Rehabilitation" and a symposium on "Public Relations." Papers will be presented on "Presentation of Health Material on the Radio," "Newspaper and Class Organs," "Speakers' Bureaus," "Silent and Talking Pictures." Discussions on this symposium will be led by Dr. F. C. Warnhuis.

The annual banquet of the Association will be held at the Mission Inn on Friday night, and the annual business meeting will be conducted at luncheon on Saturday.

The committee who have prepared the program is composed of Dr. R. H. Sundberg of San Diego, Mr. James G. Stone of Los Angeles, and the late Dr. Thomas C. O'Connor, Jr., of Stockton.

For other information, write to W. F. Higby, Executive Secretary, California Tuberculosis Association, 45 Second Street, San Francisco.

All physicians are cordially invited to attend this meeting.

New York Polyclinic Medical School and Hospital. Dr. Russell L. Cecil, professor of internal medicine at the New York Polyclinic Medical School and Hospital, gave a special afternoon lecture on Wednesday, January 13, on "Streptococcal Infections and Their Treatment."

The following program will be presented at the March meeting of the Polyclinic Clinical Society:

"The Vermiform Appendix: Its Physiology and Pathology" by Dr. H. A. Royster of Raleigh, North Carolina; "Carcinoma of the Breast," with sound films in color, by Dr. Herbert C. Chase.

Coming Conventions: Military Surgeons; Railway Surgeons; Orthopedic Surgeons.—The Association of Military Surgeons of the United States announces the appointment of Mr. Robert Lewin as director of its convention exhibits.

Mr. Lewin has very successfully directed the commercial exhibits of the American Association of Railway Surgeons and the American Association of Orthopedic Surgeons for a number of years. This year he is also directing the commercial exhibit held in conjunction with the International Fever Therapy Conference at the Waldorf-Astoria, March 29 to 31.

The commercial exhibits of the Association of Military Surgeons have been creating more attention each year, and the exhibitors have found this to be a highly profitable meeting.

Anyone desiring information in connection with the Military Surgeons 1937 convention to be held at Los Angeles, October 14 to 16, the American Association of Orthopedic Surgeons to be held at the Biltmore Hotel, Los Angeles, January 15 to 19, the American Association of Railway Surgeons meeting to be held September 21 to 22 at the Palmer House in Chicago, or the International Fever Therapy Conference, as above mentioned, should address Mr. Robert Lewin, 505 North Michigan Avenue, Chicago, Illinois.

What Happens to Medical Fees for Saving the Injured?—In the city of New York thousands of doctors draw very considerable fees from accident cases. These fees do not always come from the injured person, but oftener from the insurance companies. They are not always paid willingly or entirely, and are frequently subject to adjustment. Nearly 2,000 of such fees are in controversy in the city of New York, entailing a delay for the doctor in obtaining remuneration and for the insurance company in clearing its record.

But New York State is trying a new experiment for adjusting such fees equitably and expeditiously.

Inspired by the voluntary arbitration system of the National Bureau of Casualty and Surety Underwriters, the amendments to the New York Workmen's Compensation Act passed in 1935 contain a provision for the arbitration of disputes on medical fees.

The Compensation Insurance Rating Board, in conference with officials of the Labor Department and the American Arbitration Association, has worked out an administrative plan for making this provision effective. Under this plan the insurance carrier files an objection with the Industrial Commission, with which is also filed an agreement to arbitrate and to abide by the award which is signed by both parties to the dispute. The Rating Board then arranges for a hearing before four arbitrators, two appointed by each side from special panels of doctors that have been appointed for the purpose through the cooperation of the county medical societies. When the four arbitrators fail to agree on a decision, they select a fifth doctor whose decision then becomes final. It is anticipated that the questions arbitrated will involve not only the size of the doctor's fees, but also his competency and his disposition to follow ethical standards.

The *Arbitration Journal* (521 Fifth Avenue, New York) for January tells the story of this experiment, describes the law under which it is being made and the machinery for making such adjustments. The story is part of a symposium on Arbitration in Insurance, which portrays the whole picture of what the insurance companies and arbitration are doing to meet the problems which arise after an accident has occurred.

East Bay Hospital Conference.—The East Bay Hospital Conference, composed of all the hospitals on the approved list, as issued by the American College of Surgeons in Alameda County, held its annual meeting on January 21, at a luncheon at Peralta Hospital in Oakland.

At the election of officers which ensued, Ellard L. Slack, Superintendent of Samuel Merritt Hospital, Oakland, was elected to succeed George U. Wood, Superintendent of Peralta Hospital, Oakland, as president. Dr. Benjamin W. Black, Director of Alameda County Institutions, was elected vice-president, to succeed Miss Florence Klaeser, Superintendent of the East Oakland Hospital. Alfred E. Maffly, Superintendent of Berkeley General Hospital, was reelected secretary-treasurer.

"Giving Information to the Press," the standard code on this subject, recommended by the American Hospital Association, was adopted as a standard for all members of the Conference. Dr. Robert P. Legge, professor of hygiene and university physician of the Cowell Memorial Hospital at the University of California, spoke on "The Control of Venereal Disease" as outlined by Surgeon-General Parran, at a meeting of the United States Public Health Service held in Washington, D. C., on December 28.

Dr. Benjamin W. Black, Medical Director of Alameda County Institutions, spoke on the "Relationship of the County Hospital to the Voluntary Hospitals."

Rosenwald Fund Makes Grant for Medical Economics Study.—The Julius Rosenwald Fund has made a grant of \$165,000 over a five-year period, to the Committee on Research in Medical Economics, it was announced by Edwin R. Embree, president of the Fund. This committee has recently been incorporated in New York, with Michael M. Davis as chairman, the other members being Robert E. Chaddock, professor of statistics, Columbia University; Henry S. Dennison, president of Dennison Manufacturing Company, Farmingham, Massachusetts; Walton H. Hamilton, professor of law, Yale University, and director of Bureau of Research, Social Security Board, Washington; Elvin S. Johnson, director of New School for School Research, New York; Paul U. Kellogg, editor of *The Survey Graphic*, New York; Harry A. Millis, professor of economics, University of Chicago; Fred M. Stein, retired banker, New York.

The committee will have an Advisory Board, to be enlarged as required, the following physicians now being members: Doctors Samuel Bradbury of Philadelphia, Alfred E. Cohn of New York, Alice Hamilton of Washington, Ludwig Hektoen of Chicago, and Franklin C. McLean of Chicago.

This committee will conduct and assist studies in the economic and social aspects of medical care; will train personnel for this field; and, in cooperation with the medical profession and other agencies, will furnish information and consultation services in behalf of rendering medical care more widely available to the people at costs within their means. The committee will have headquarters in New York City.

Since 1928, Mr. Embree stated, "the Julius Rosenwald Fund has been actively at work with the aim of reducing the costs of medical services and of making them more accessible to people of small incomes. Now the organized medical profession, hospitals, and many industrial and governmental agencies are engaged in practical experiments in different parts of the country, organizing medical care to reduce costs or developing methods of getting these costs into the family budget.

"Hence there is now less need for the promotion of action than for the guidance of action through scientific and dispassionate studies. The Fund, therefore, welcomes the opportunity to make a grant of this kind to a committee of social scientists and business men, with a distinguished medical advisory board. With this grant, together with the grant of \$100,000 recently made to the American Hospital Association to promote voluntary hospital insurance, the trustees have terminated their department of medical services, believing that these two agencies will now carry forward vigorously the Fund's long-standing and successful work in this field."

Examination for Entrance into the Medical Corps of the Navy.—An examination for commission in the Medical Corps of the United States Navy and for appointment as internes in the Medical Corps of the United States Navy will be held, beginning May 10, this year. There are about fifty vacancies in the Corps to be filled. The examination will be held at all United States naval hospitals and the United States Naval Medical School, Washington, D. C.

Candidates for admission must be between the ages of 21 and 32 years at the *time of appointment*, graduates of or senior medical students in Class "A" medical schools only.

Those who are interested should write the Surgeon-General, United States Navy, Bureau of Medicine and Surgery, Navy Department, Washington, D. C., for further information in regard to the examination and the procedure to follow for them to appear before one of the examining boards.

Sewage Treatment Works in the East.—C. G. Gillespie, Chief of the Bureau of Sanitary Engineering of the California Board of Health, in a recent report stated:

"While on vacation in the East attending an engineering conference this month, the Chief of the Bureau took occasion to visit a number of the newer and larger sewage treatment and water treatment works in the vicinity of the Great Lakes and Washington, D. C. Of some sixteen sewage plants visited, ten are exceptionally large and nearly all of them have been built or under construction during the last three or four years at the following places: Minneapolis, Milwaukee, Chicago, Cleveland, New York, and Washington, D. C. These ten plants serve almost ten million people and handle from 1,000,500,000 gallons to 3,000,000,000 gallons of sewage daily. The figure represents approximately seven times the total sewage production in all of California. The investment in sewage treatment works is approximately \$65,000,000 and, in addition, there is the expense of sewage interception to reach the plants, amounting to even a larger sum. Daily operating personnel exceeds one thousand men.

"One may see in these plants, representing as they do the best wisdom of this day, practically all of the newer ideas in stream pollution abatement and sewage treatment. How experience pays is illustrated in the case of two plants of similar type and for similar purpose in one of these cities where the most recent plant saves in the neighborhood of \$7,000,000 over the cost of the earlier one.

"One cannot escape the impression that sewage treatment is now in a new era, utilizing monumental works inheriting much of the handiwork of the power plant and electrical engineer. In fact, many of the plants present the appearance of high-grade industrial enterprises surpassed by few industries in architectural embellishment and mechanical orderliness.

"Yet the impression remains that these cities have not been extravagant. The scope of works and provision for the future is consistent with the needs in each particular case. Thus, Chicago, with almost no stream for dilution, turns to activated sludge treatment, graded down, however, for the actual needs of effluent as nearly as it can be predicted. Cleveland and Milwaukee, on the other hand, with recreational lake fronts to preserve, go to the highest degree of treatment in their activated sludge plants. At the other extreme, Washington, D. C., with the broad Potomac to receive the effluent, stops at simple sedimentation. In between, fall Minneapolis and the Coney Island Plant of New York City, where the processes are intermediate in results and costs. Minneapolis drains its effluent to the Mississippi River, having a considerable summer flow, and capitalizes on it. The Coney Island Plant capitalizes on its length of outfall into the ocean to reduce the degree of its sewage treatment.

"Sludge disposal, always the bane of handling sewage, is being met on an increasing scale by filtering the water out of the sludge and incinerating the sludge cake at high temperature, the same as is done with garbage.

"Coming home to the tendencies in California, the aim is toward a higher standard on proportionately less money than is represented in these eastern plants. We would succeed better were our economic 'sights' raised a little higher so as to do the job more adequately."

Thirty-Third Annual Congress on Medical Education and Licensure.—This year's conference was held on February 15 and 16 at the Palmer House, Chicago. The program included the following papers:

MONDAY MORNING, 10:00

Ray Lyman Wilbur, M. D., Presiding

Report of the Council on Medical Education and Hospitals. Ray Lyman Wilbur, M. D., LL. D., Chairman, Stanford University, California.

The Regulation of the Professions in the Public Interest. William E. Wickenden, B. S., President, Case School of Applied Science, Cleveland.

The Price of Professional Liberty. Guy Stanton Ford, Ph. D., Dean, University of Minnesota Graduate School, Minneapolis.

The Medical School Survey. Herman G. Weiskotten, M. D., Dean, Syracuse University College of Medicine, Syracuse, New York.

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MONDAY AFTERNOON, 2:15

Reginald Fitz, M. D., Presiding

Report of the Survey to Individual Schools, William D. Cutter, M. D., Secretary, Council on Medical Education and Hospitals of the American Medical Association, Chicago.

Symposium on Cancer

Biology of Cancer. C. C. Little, Sc. D., Director, Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine.

Pathology of Cancer. Francis Carter Wood, M. D., Director, Institute of Cancer Research, Columbia University College of Physicians and Surgeons, New York.

The Teaching of Cancer. Frank E. Adair, M. D., Secretary, American Society for the Control of Cancer, New York.

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MONDAY AFTERNOON, 2:45

The Federation of State Medical Boards

James N. Baker, M. D., Presiding

Medical Licensure as Related to the Practice of Medicine. Edward H. Cary, M. D., Chairman, Committee on Legislative Activities of the American Medical Association, Dallas, Texas.

The Fallacy of Spinal Adjustment. Thomas J. Crowe, M. D., Secretary, Texas Board of Medical Examiners, Dallas.

The Doctor and the Narcotic Violator. R. L. Sensenich, M. D., Past President, Indiana State Medical Association, South Bend.

A Lawyer's Point of View on the Narcotic Problem. Herman B. Carlson, Director, Division of Law Enforcement, Iowa, Department of Health, Des Moines.

Some Medical Licensure Problems of Massachusetts. Edward A. Knowlton, M. D., Member, Massachusetts Board of Registration in Medicine, Holyoke.

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TUESDAY MORNING, 9:30

Joint Session of the Council on Medical Education and Hospitals and the Federation of State Medical Boards

James N. Baker, M. D., Presiding

Symposium on the Selection of Students

Primary Mental Abilities. L. L. Thurstone, Ph. D., Professor of Psychology, University of Chicago.

Measurement of Personality. E. K. Strong, Jr., Ph. D., Professor of Psychology and of Applied Psychology, Stanford University Graduate School of Business, Stanford University, California.

The Why, What, and How of the Medical Scholastic Aptitude Test. Torald Sollmann, M. D., Dean, Western Reserve University School of Medicine, Cleveland.

Symposium on Technique of Examination

Philosophical Comments on Examinations, Howard T. Karsner, M. D., Director, Institute of Pathology, Western Reserve University, Cleveland.

Fundamental Purposes, Methodology, and Techniques of Examining in Relation to Medical Education and Licensure. Ben D. Wood, Ph. D., Associate Professor of Collegiate Educational Research, Teachers College, Columbia University, New York.

The Essay Examination on the Spot. Robert P. Dobbie, M. D., Assistant Professor of Surgery, University of Buffalo School of Medicine, Buffalo, N. Y.

TUESDAY AFTERNOON, 2:15

Charles E. Humiston, M. D., Presiding

Medicine in Education. Max Mason, Ph. D., California Institute of Technology, Pasadena, California.
 Relation of the American Medical Association to the Certification of Specialists. Charles Gordon Heyd, M. D., President, American Medical Association, New York.
 Increase in the Number of Practitioners in the Country. Harold Rypins, M. D., Secretary New York Board of Medical Examiners, Albany.
 Graduate Instruction and the State Medical Association. Charles R. Scott, M. D., Twin Falls, Idaho.

MONDAY EVENING, 6:30

The Federation of State Medical Boards
Annual Dinner

Address: James N. Baker, M. D., President, The Federation of State Medical Boards of the United States, Montgomery, Alabama.
 Address: Licensure and the Organized Profession. Charles Gordon Heyd, M. D., President, American Medical Association, New York.
 Round-Table Discussion.

MONDAY AFTERNOON, 12:30

Central Council for Nursing Education

Luncheon for Lay Boards of Hospitals and Public Health Nursing Organizations.
 Address: How Nursing May Promote Interprofessional Relationships. Joseph C. Doane, M. D., Philadelphia.

Regulations of the California Department of Public Health for the Prevention of Syphilis and Gonococcus Infections.—It shall be the duty of every person who gives treatment for syphilis or gonorrhea to report in writing immediately to the local health officer within whose jurisdiction such patient is, on a card supplied by the State Department of Public Health, the patient's initials, sex, and date of birth.

The local health officer shall forward these reports to the State Department of Public Health at least weekly.

The physician shall keep a record by name and address of each patient treated.

The name and address of the patient shall be reported to the local or state health official to whom the attending physician is required to report such case, upon the special request of such official if in his judgment this may be necessary to prevent the spread of the disease to other persons.

Whenever any person suffering from syphilis or gonorrhea shall discontinue treatment while, in the judgment of the attending physician, he is capable of transmitting the disease to others, such physician shall report immediately such facts together with the patient's initials and date of birth to the local or state health official to whom the attending physician is required to report such case.

Records of any local department of health or of any local health officer or of any laboratory, clinic or other institution, relating to cases of syphilis or gonorrhea, shall be confidential except in so far as may be necessary to carry out the provisions of the law and these regulations.*

Hospital Convention at Los Angeles: Hotel Biltmore, April 12 to 15.—The eleventh annual exposition and convention of the Association of Western Hospitals, Association of California Hospitals, western conferences of the Catholic Hospital Association, and allied groups and sections, will be held on April 12 to 15 at the Biltmore Hotel, Los Angeles. The preliminary program announces the following:

1. "The Manifold Obligations of the Hospitals to the Public"

This session will be a searching study of how well you serve your communities. It will set standards of community service. It will tabulate your community responsibilities. It will emphasize the dignity to your profession.

The speaker will be an experienced hospital administrator able to drive home an inspirational message.

* See also article in Miscellaneous department, on page 212.

2. "Legislation and Hospitals"

A timely topic with the multitude of bills and laws confronting us. It is planned to stress this from the "lobby" or "pressure-group" viewpoint. Many pressure groups are already with us. Others may be expected. This session should be very instructive to hospital administrators interested in the legislative problems of hospitals.

We plan to have a specialist in government technique present this lecture.

3. "Group Hospitalization"

(a) Is it a fact or a fancy? Has prosperity removed the necessity for it? These questions will be answered by an able speaker who will come from a plan that is working successfully.

(b) What are the helps and hindrances to its broad scale development? What is the responsibility of private hospitals? These, likewise, will be answered by a recognized authority.

4. "The Interest of the Patient Is Paramount"

Economy and budget balancing have occupied the minds and energies of administrators for several years. It is time to check up on your quality of service. Do you pass muster on scientific and sanitation facilities? These are minimums of service. Do you recognize the peculiar psychology of patients? Do your employees conduct themselves accordingly? What services do you render beyond the minimums of scientific safety and proper sanitation? There are many you must provide to really meet the true spirit of rendering hospital care to the sick. The speaker will delve deeply into this subject and should cause many administrators to recognize and develop a new sense of dignity of service in our profession. The speaker will be chosen because of experience, ability, and an appreciation for the intangible elements of service.

5. "The Growth, Causes, and Cures of Malpractice Suits"

This has always been a grievous problem to hospitals. Recently there has been a serious growth of such litigation. Some damaging decisions have been rendered recently. It is a delicate, difficult problem affecting every hospital. This session will candidly study the hazards that exist, the methods of preventing accidents, the legal procedure required to protect your institution when not at fault.

Perhaps we shall stage a pseudo trial to bring out dramatically the points of danger in such a suit. Handled by capable attorneys it will drive home its message in a new potent manner.

6. "Employee Welfare in the Broader Sense"

Leadership is a trait vitally necessary in every hospital. In the spirit of leadership, we shall discuss the importance of employee welfare. How do judgment, tact, kindness grow? Hospitals render mainly service and it is a product made only from human ingredients. We need to evaluate anew the employees' importance. New consideration must be given to this problem. This is necessary to insure the proper spirit in service to the ill, and to insure against labor disputes. We wish to avoid unionization of hospital employees.

The speaker will be a national authority on the subject. Do not miss this session. It bids to be one of your biggest days, provoke much discussion, perhaps a real debate.

Round Tables.—Each General Assembly will be followed by a one-hour round table. In this hour many can participate. Able leaders will be drafted to lead this hour of personal discussion. It is the hope of the Committee that truths can be driven home, different points of view presented, and a well-rounded conclusion carried away with each delegate. Petty issues will be ignored and vital problems emphasized.

Sectional Meetings.—Without losing the good in general assemblies, sectional meetings are being arranged without schedule conflicts. Dietitians, nurses, social workers, Auxiliary members, trustees, accountants, engineers, housekeepers, record librarians, will have programs of merit on vital hospital problems.

Exhibits.—Space for exhibits is already sold out. This feature promises to be better than ever. The latest and best will be available for your scrutiny and instruction. In four days you can get first-hand knowledge that would take months except for this convention.

Eating Habits of Past Generations Affect Our Teeth.

The modern doctor is now as much concerned about what sort of patient has the disease as he is about what sort of disease the patient has, Dr. John A. Marshall of the University of California College of Dentistry, told the members of the Los Angeles County Dental Society at a meeting held here. This necessity of studying the patient to determine habits, past ailments and hereditary defects, is coming to mean more and more in the practice of dentistry, Doctor Marshall said.

Doctor Marshall pointed out that there is some foundation of fact in the supposition that the dietary habits of the Americans of a few generations ago are having their effect upon the present generation, particularly in respect to tooth health.

"The average American of 1800 was as ignorant of food values as he was of sanitation, physiology, or anesthesia. Dairy products, vegetables, fruit, fish, and so forth, were used sparingly or were not even thought of. Whether these past dietary derelictions have had any ill effect upon the present generation is difficult to prove. However, the great number of nutrition experiments that have been carried on throughout the world indicate that such supposition has some foundation of fact."

However, Doctor Marshall pointed out, it will be a hundred years or more before the full effect of present corrective dietary systems will become apparent in human teeth.

The speaker emphasized the thought that dental diseases are not merely local lesions, unrelated to the rest of the alimentary tract, nor are they merely local manifestations of systemic diseases. "They are both, and because they are both, the etiology, the prognosis, and the treatment will always be difficult," he said. "But unfortunately the results of dental therapy—surgical, operative, dietary, and medicinal—fall far short of what we would wish."

Smiths, Johnsons, and Eight Others.—The United States Social Security Board announces that the Smiths once more have proved their numerical leadership by being the most frequent of all the names among the millions of wage-earners who will have social security accounts for participation in the federal old-age benefits program, the Social Security Board announced recently in stressing the importance of assigning a specific number to the account of every worker.

Preliminary estimates, the Board states, indicate that ten names—the Smiths, the Johnsons, the Browns, the Williamses, the Joneses, the Millers, the Davises, the Andersons, the Wilsons, and the Taylors—will constitute more than 1,500,000 of the total number of workers who will participate in the federal old-age benefits program.

The Board's Wage Records Office is setting up accounts for approximately 294,000 Smiths, 227,000 Johnsons, and 164,000 Browns. These are followed closely by the Williamses with a total of 156,000; the Joneses, 147,000; the Millers, 137,000; the Davises, 123,000; the Andersons, 115,000; the Wilsons, 96,000; and the Taylors 81,000.

If numbers for the accounts were not used, it would be necessary to obtain elaborate information about each worker on every wage report to insure accuracy in recording wages, the Board states. The use of the number makes the maintenance of such a vast system of accounts practicable and permits the use of an application blank asking for only simple information.

Estimates of the number of persons with these ten names are based on the assumption that approximately 26,000,000 wage-earners would participate in the old-age benefits program. Employers' application forms for identification number (SS-4), on file with the Board as of January 15, show that the approximate number of persons now in their employ totals 26,024,938.

The Post Office Department's count of the employee applications on file in typing centers as of December 16 was 22,129,617. Since then a large number of additional employee's applications for social security account numbers have been received daily.

Western Branch: The American Public Health Association.—The Western Branch, American Public Health Association, will hold its eighth annual meeting in Phoenix, Arizona, April 13 to 15. The program will be devoted to discussion of public health matters of special interest to the West, and will present speakers of national and western prominence.

Inquiries should be addressed to Dr. George C. Truman, State Superintendent of Public Health, Phoenix, or to Dr. W. P. Shepard, 600 Stockton Street, San Francisco.

Golden Gate Bridge Fiesta.—The completion next May of the great Golden Gate Bridge, longest suspension span ever constructed, will be the signal for a spectacular four-day celebration in San Francisco, which promises to echo round the world.

Sweeping majestically across San Francisco's famed Golden Gate, through which the Argonauts first glimpsed the land of their golden hopes eighty-eight years ago, this gigantic bridge will be among the most impressively beautiful structures built by man.

The Golden Gate Bridge Fiesta, as the opening celebration will be known, is aimed to eclipse anything of its kind ever seen in the West, and plans already advanced call for a series of brilliant and colorful land, water and aerial pageantry, and other activities for four wondrous days and nights.

The celebration is to be international in scope, for the \$35,000,000 bridge will break the last major water barrier to the north of San Francisco and offer a continuous highway between Canada and Mexico via San Francisco and the Redwood Empire along the northern coast of California.

The Army and Navy have pledged the fullest coöperation for the celebration and every available warship in the fleet in Pacific waters will be assigned to San Francisco harbor for the duration of the festivities.

On bridge-opening night, the warships will focus their powerful spotlights on the span, which will also be brilliantly illuminated with flood lights suspended from the high towers. Colored bombs bursting in air, together with a mile-wide display of fireworks, will signalize the first formal illumination of the great bridge.

The Golden Gate Bridge, financed by public bond issues in San Francisco and five Redwood Empire counties, is even more spectacular than the state-operated and federal-financed San Francisco-Oakland bay bridge, which connects San Francisco with Oakland and cities on the east and which was opened last November.

As the highest and longest single span suspension bridge in the world, the Golden Gate Bridge has a main span of 4,200 feet and an overall length of 9,200 feet. The main span is 700 feet longer than the George Washington Bridge across the Hudson River at New York City, and the towers are 150 feet higher; the towers are also 191 feet higher than the Washington monument. The floor of the bridge is 250 feet above the seven-mile an hour tides that continually sweep in and out of the entrance to San Francisco Bay.

Construction of the pier 1,200 feet offshore from the San Francisco side in 100 feet of water was one of the most daring and unusual in bridge-building history, being the first bridge pier built in an open sea. The work of this pier was carried on inside a permanent steel and concrete "fender pier" 750 feet in circumference and 115 feet high.

The steel towers, extending 746 feet above mean high water, will serve as aerial beacons and possibly for radio broadcasting. There will be complete independent telephone, fire and police telegraph systems on the bridge. The annual capacity of the span has been estimated as seventy million passenger cars and six million trucks.

Construction of the bridge was begun in January, 1933, and the cost of \$35,000,000 will be paid from collected tolls. Joseph B. Strauss is chief engineer of the structure.

The Golden Gate Bridge Fiesta in May will be a forerunner of the Golden Gate International Exposition in 1939 to celebrate completion of both the San Francisco-Oakland Bay Bridge and the Golden Gate Bridge.

International Conference on Fever Therapy.—In conjunction with the International Conference on Fever Therapy to be held at the Waldorf-Astoria Hotel on March 29 to 31, there will be a scientific and commercial exhibit staged.

The clinics will be held at the College of Physicians and Surgeons, Columbia University, New York City.

A large attendance of fever therapists from all over the world is expected. A very interesting and instructive program has been arranged, and all of those who plan to attend the conference are urged to register promptly with the general secretary, Dr. William Bierman, 471 Park Avenue, New York City. The registration fee is \$15.

Monthly Statement of Venereal Diseases Reported in California.—The Treasury Department of the Public Health Service, in its December report, gives the following figures for California:

State and Cities	Syphilis		Gonorrhea	
	Cases Reported During Month	Monthly Case Rates Per 10,000 Population	Cases Reported During Month	Monthly Case Rates Per 10,000 Population
California	1,508	2.67	1,542	2.73
Los Angeles*			42	1.39
Oakland	45	1.48	147	2.19
San Francisco	152	2.27		

* No report for current month.

Social Security "Severance" Reports of Employees Leaving Service.—To insure eligible workers their full rights to benefits under the unemployment compensation provisions of the Social Security Act, the National Social Security Board has ruled that wage-earners shall not be required to sign "severance" reports. This is a form on which the employer reports to his State unemployment compensation administration when any employee subject to the law leaves his employ, giving the reasons therefor.

The purport of this ruling, which now becomes effective in the thirty-five states and the District of Columbia having unemployment compensation laws approved by the Board, will be to protect workers from being virtually forced into agreeing to postponement or possible loss of their unemployment compensation benefits. . . .

When Employer Voluntarily Pays Employees' Tax.* United States Commissioner of Internal Revenue Guy T. Helvering announced that amounts voluntarily paid as employees' tax by an employer, without collecting such amounts from his employees, are not wages subject to the taxes under Title VIII of the Social Security Act.

Title VIII of the Social Security Act imposes two taxes, an income tax on employees and an excise tax on employers, both of which became effective January 1, 1937. The initial rate of each of these taxes is one per cent of the wages of the employee. The law makes provision for the employer to collect the income tax on employees by deducting the amount thereof from the wages of each employee when they are paid.

After the close of each calendar month both the amount of the tax on the employer and, whether or not collected from his employees, the amount of the employees' tax must be paid by the employer to the collector of internal revenue. The taxes with respect to all taxable wages paid by the employer during a calendar month are required to be paid to the collector within the succeeding month. Form SS-1, the monthly return to be used by employers for this purpose, is available at the offices of all Collectors of Internal Revenue.

A number of employers have made known a desire to pay the employees' tax under Title VIII without deducting the tax from the remuneration of their employees. They have requested a ruling whether the amount so paid by them will itself be subject to the taxes under that title of the Act. The amount of the employees' tax in such case, if voluntarily paid by an employer, is not considered as additional wages subject to either the employer's tax or employees' tax imposed by Title VIII of the Act.

* See also item in Special Articles in this issue of CALIFORNIA AND WESTERN MEDICINE, on page 214.

LETTERS

Concerning the fight against syphilis.

TREASURY DEPARTMENT
PUBLIC HEALTH SERVICE
WASHINGTON

January 28, 1937.

To the Editor:—I wish to thank you for your letter of January 15 and the copy of the January issue of CALIFORNIA AND WESTERN MEDICINE. Your editorial, entitled "The Fight Against Syphilis: Long Delayed, Off on a Good Start," has been read with considerable interest, and I hope, as you say, that the time is now ripe for a well-organized campaign and that the funds available through the Social Security Act will stimulate this work in State and local health departments.

Sincerely yours,

R. A. VONDERLEHR,
Assistant Surgeon-General,
Division of Venereal Diseases.

Concerning "throw-away" publications.

January 20, 1937.

To the Editor:—There is an increasing tendency of some so-called "throw-away" publications to reprint, without permission, material appearing in the more ethical medical publications.

At the last meeting of the Committee on Publication of the Official Journal of the Minnesota State Medical Association it was decided to formally notify such publications not to reprint any material from *Minnesota Medicine* without written permission from the Editor or the Committee on Publication.*

It is our opinion that if every recognized medical publication would take similar action, it would materially aid in correcting a practice that is both unfair and unethical. *Minnesota Medicine* is sending a notice to four such publications (Medical Economics, Modern Medicine, Current Medical Digest, and the New York Physician), by registered mail, return receipt requested, although we do not know at this time whether any of them have reprinted material without permission.

Very truly yours,

MINNESOTA MEDICINE.
C. B. DRAKE, Editor.

Concerning silicosis.

To the Editor:—The Medical Committee of the Air Hygiene Foundation of America, 4400 Fifth Avenue, Pittsburgh, Pennsylvania, headed by Dr. A. J. Lanza, Chairman, announces the completion of a comprehensive treatise on "Silicosis and Allied Disorders." The Committee has attempted to bring together in one report a summary of those phases of pneumoconiosis which have been the subject of research, those which have been settled more or less conclusively, and those demanding further investigation.

The report, designed for industrialists as well as physicians, offers a practical, six-point program of health control for the "dusty trades." Recommendations for research along four fundamental lines are submitted to the Foundation in the report. These researches represent those which the Committee agrees are most urgently needed at the present time to increase our knowledge of pulmonary diseases which may result from air pollution. . . .

The conclusion of the report is a summary, which follows:

The extensive studies of silicosis in this country and abroad have given us a very clear idea of the cause of this disease, its pathology, its complications, and its prognosis. On the basis of our present knowledge, it may be said that:

1. Silicosis results from the inhalation of dust containing free silica.

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2. The time required for the development of silicosis varies from a few years to twenty or more, depending on the concentration of silica particles in the air and the constancy of exposure.

3. Beginning silicosis is recognizable only by properly taken roentgen films of the chest; small nodular shadows distributed throughout both lungs are the characteristic appearance. There are no symptoms or physical signs associated with early simple silicosis which can be depended upon for making diagnosis.

4. Associated with silicosis is a marked predisposition to tuberculosis.

5. Silicosis can be prevented by protecting the industrial worker from inhaling silica dust. This may be accomplished by engineering measures.

6. Concentrations to which the dust must be reduced in order to be safe have not been absolutely determined.

7. Industrial dusts, containing silica, are frequently not all silica, being mixed with other materials. It is possible that some of these nonsilica components may prevent or modify the action of silica in the body and may alter the tendency toward complicating silicosis.

8. Asbestos, which is a silicate, is the only dust other than free silica which has been shown to cause a lung fibrosis with disability.

9. Simple—that is, uncomplicated—silicosis, as seen in industries in the United States, causes relatively little severe disability.

Control of silicosis calls for adequate medical and engineering measures.

A practical program of preemployment examination of all workers exposed to dust containing silica is essential. Such examinations should include a complete physical examination of each individual, a careful history of past occupational exposure to dust, and a chest roentgenogram with standard technique.

The value of such procedure may be summarized as follows:

1. Protection of prospective employees, who may have diseased lungs, from silica exposure.

2. Discovery of the hazardous jobs, as a result of finding the silicosis cases, in order to eradicate these hazards.

3. Discovery of active and open cases of tuberculosis which are in contact with other employees, especially protecting the younger workers who are susceptible to contact infection.

4. Discovery, through periodic examination of those with inactive tuberculosis, of any reactivation of their tuberculosis before they have been active too long, so as to protect especially the younger employees. This also offers the infected individual a better chance for a cure of his tuberculosis.

5. Discovery of early cases of simple silicosis through periodic examination to give them added protection from further excessive dust exposure.

6. Determination, through periodic physical examination, of the adequacy of the dust control program.

A careful consideration of the foregoing summary as well as the varied experiences of the members of the Medical Committee clearly indicate that there is a wide field for research still in this matter of pulmonary dust diseases.

The following research projects are listed, therefore, for the consideration of Air Hygiene Foundation:

(a) Relationship between silicosis and tuberculosis, with especial reference to the question of activation or reactivation of tubercle infection consequent upon exposure to silica, especially in massive doses, over a short period in the absence of definite evidence of silica action (nodulation) in the tissues.

(b) The effect of other substances upon the action of silica in the body. It has been claimed that where other substances are present in the dust with silica, they may retard the action of silica so as to actually prevent, or, at least, delay the development of silicosis. Meanwhile, certain other substances have been credited with greatly intensifying the action of silica.

(c) Study of the mechanism by which silica exerts its injurious effects upon the body. The pathologist can demonstrate what silica does in the pulmonary and other

tissues of the body, but so far no reasonable explanation has been offered or demonstrated as to why silica acts as it does.

(d) Research in the technique of roentgenography. In the last few years the technique of taking x-ray films has greatly improved. Inasmuch as it would appear that to an ever-increasing extent preemployment medical examinations will include chest roentgenograms, a man may be hired or rejected on the basis of his x-ray film. It is, therefore, evident that the very best technique that can be evolved is the least with which industry can be satisfied.

H. B. MILLER, *Managing Director.*

Concerning heavy incidence of bovine tuberculosis in California.*

CALIFORNIA TUBERCULOSIS ASSOCIATION

February 19, 1937.

To the Editor:—California is the black spot . . . of the nation in bovine-tuberculosis control. By July first of this year it will be the only state not a modified accredited area (i. e., less than 0.5 per cent of cattle infected). This state has more diseased cattle than the rest of the United States combined. Other states are threatening quarantines against California dairy products. The public health is still menaced by bovine tuberculosis.

Your participation is needed at a state-wide conference of leaders of economic, public health and public welfare organizations and groups which has been called by the California Tuberculosis Association for the purpose of crystallizing public sentiment for an adequately financed and rapidly moving program for the reduction of bovine tuberculosis to a point that will entitle California to become a modified accredited area.

California is so far behind other states in this movement that it is absolutely essential the State Legislature, which will reassemble next month, shall make adequate financial provision for the program. Unless this is done, the clean-up of the State will be long drawn out. We are confident, however, that if the legislature can be sufficiently impressed with the weight of public interest in this matter, it will respond to public sentiment by making the necessary appropriation.

We regard the situation as acute and important enough to justify you in attending this conference, which will be held in the auditorium of the Pacific Gas and Electric Company, 245 Market Street, San Francisco, on Wednesday morning, March 3, at ten o'clock.

Sincerely yours,

CALIFORNIA TUBERCULOSIS ASSOCIATION.

W. F. HIGBY, *Executive Secretary.*

45 Second Street, San Francisco.

Has Teaching Improved?—An excerpt from *Actions and Reactions: An Autobiography of Roger W. Babson*, 1935, follows:

I think that the success of teaching is nine-tenths in the teacher, and one-tenth in the buildings and textbooks. I would much rather have my grandchildren have teachers with a few diplomas and big hearts than teachers with many diplomas and little hearts. The present fad, that a school principal must have a Ph.D. in order to get a position is all rot. I would much rather know he loves his work and his pupils.

Ph.D.'s do not necessarily make good teachers.

A thousand years from now no building or curriculum will ever take the place of a conscientious and praying school teacher.

I do feel that the health of a teacher is an important factor: in many instances the teacher is cross and impatient because not in good physical condition.

I should give teachers regular physical examinations, and insist that they keep in good condition physically and nervously.

I should forget the Ph.D.'s and turn them over to the M.D.'s.

* The subject of Tuberculosis, in recent numbers of CALIFORNIA AND WESTERN MEDICINE was mentioned in the following issues: Vol. 44, No. 5, May, 1936, advertising page 7; Vol. 45, No. 1, July, 1936, advertising page 26; Vol. 46, No. 1, January, 1937, advertising page 30; and Vol. 46, No. 2, February, 1937, advertising page 44.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

If a sponge or drainage tube is allowed to remain in a patient after a surgical operation, the patient may commence an action for malpractice after the expiration of one year from the time of the operation.

In *Huysman vs. Kirsch*, 6 Cal. (2d) 302, plaintiffs (husband and wife) brought a suit against a surgeon for malpractice alleged to have resulted from the failure of the surgeon to remove from the body of the wife a drainage tube used by the surgeon during an operation on the wife. The plaintiffs alleged that the defendant surgeon negligently allowed the drainage tube to remain in the wife's body after its purpose had been fully accomplished, and that the plaintiffs had no knowledge of this. The operation was performed in January, 1931. The drainage tube was removed in September, 1932. The action for malpractice was commenced in January, 1933. The defendant contended that because of the one-year statute of limitations applicable in malpractice cases, the action had been filed too late. The trial court agreed with the defendant's contention and gave judgment for defendant. From this judgment the plaintiffs appealed. The District Court of Appeal affirmed the judgment, relying upon the prior decision in *Gum vs. Allen*, 119 Cal. App. 293 (where it was held that a plaintiff could not sue for malpractice based upon negligence in leaving a sponge in her body after the expiration of one year from the date of the operation). The opinion of the District Court of Appeal is the subject of a comment in the *Journal of the American Medical Association*, February 1, 1936, at page 410.

Huysman vs. Kirsch was then heard by the Supreme Court. The Supreme Court reversed the District Court of Appeal, overruled *Gum vs. Allen*, and held that the action was not barred by the statute of limitations. The Court adopted the view that the statute of limitations did not start to run until the drainage tube was removed, because the act of negligence involved was the surgeon's failure to remove the tube from the abdominal cavity after it had fully served its purpose. This was said to be a continuing negligent omission lasting until the removal of the tube in September, 1932. In arriving at this conclusion, the Court cited and relied upon a New York case and an Ohio case. The following is quoted from the opinion of the California Supreme Court and indicates the Court's attitude toward this problem:

The case now before us is much stronger than either of the cases from the New York and Ohio courts. In each of those cases, the negligent act consisted in not removing the sponge from the body of the patient at the time of the operation. It might be well said that the negligence involved in those cases occurred in the performance of the operation. In the present case the operation, up to the closing of the wound and the leaving of the drainage tube therein, was entirely proper. The negligence occurred thereafter, by reason of the surgeon neglecting to remove the tube left in the patient's wound after it had served its purpose. This negligence continued during the entire time the tube was left in the body of the patient, and only ended upon the removal of said tube. With much greater reason than that which prompted the Ohio and New York courts to hold as they are shown to have done, cannot this court now hold that the surgeon's negligence continued up to the removal of said tube, and that the appellants' cause of action then accrued and would not be barred until one year thereafter? Such is the holding of this court which necessitates the overruling of the case of *Gum vs. Allen*, *supra*.

The New York and Ohio cases seem to adopt the theory that there was a continuous obligation to remove the sponge upon the part of the surgeon *so long as the employment continued*. Both courts were aware that the

action was one of tort rather than of contract, and concluded that the operation was uncompleted until the sponge had been removed. The California Supreme Court adopts as the first ground of its decision the theory that the negligent act was the failure to remove the tube after it had served its purpose. The negligence, therefore, continued until removal. Then, as a separate ground for its decision, the Court relies upon a doctrine which seems but another way of stating the continuing tort theory. The Court states:

There is another principle supported by eminent authority upon which it might be held that appellants' cause of action is not barred, and that is, that an operation like that performed upon Mrs. Huysman is not complete until the wound has been closed and all appliances used in the operation have been removed.

Evidently feeling none too sure of its position, the Court then goes further and adopts a third ground for its decision. This third ground is based upon the decision in *Marsh vs. Ind. Accident Comm.*, 217 Cal. 338. In this latter case the Court held that the statute of limitations did not begin to run against employees injured by inhaling dust-laden atmosphere until the employees knew, or by the exercise of reasonable diligence should have known, that their injuries were due to their exposure to the dust-laden air.

The reasoning of the Court with respect to its third theory is disclosed in the following quotation from its opinion in the *Huysman* case:

If we apply this principle to the facts in the present action, the same results will follow, as the appellants in this action had no knowledge of the presence of the drainage tube in the body of Mrs. Huysman until it was removed therefrom by the respondent on September 26, 1932. During all this time she was under the exclusive care of the respondent, a reputable and skillful physician and surgeon, and both Mrs. Huysman and her husband relied solely upon him for information as to her physical condition and as to her failure to regain her health. It cannot be said, therefore, that they had any knowledge whatever of the cause of her failure to recover from the operation, or that they could have gained that knowledge by the exercise of due care and diligence prior to September 26, 1932. Before that date they were as completely in the dark as to the cause of Mrs. Huysman's injury as were Marsh and his fellow workers while they were inhaling the dust-laden air in their employer's factory and until the disease resulting therefrom had reached such a stage as to indicate its cause. We can see no good reason why, if the statute of limitations did not begin to run in one case, that it should run in the other.

The actual decision in the case may thus be summarized as follows:

Where a patient does not know of the surgeon's failure to remove a drainage tube from the patient's body after its useful purpose has been fully performed, the patient's cause of action for the negligent failure to remove such tube is not barred by the statute of limitations even though the action is not brought until more than one year after the tube should first have been removed.

An important problem remains unanswered and the language of the Court will undoubtedly create confusion.

If the first and second grounds relied upon by the Court are alone considered, then the negligent omission is the failure on the part of the surgeon to remove the appliance, and knowledge upon the part of the patient would logically seem to have no possible bearing upon the running of the statute of limitations. However, there will undoubtedly be controversy as to this point because of the third ground of the decision, which was the reliance upon the doctrine of *Marsh vs. I. A. C.* It will undoubtedly be argued in future cases where the patient has acquired knowledge that the one-year period should commence from the date upon which knowledge was acquired or upon the date when knowledge could have been acquired by the use of reasonable diligence upon the part of the patient. The fact that the Court adopted a third ground for its decision which was not raised by counsel for either side, would tend to indicate that the Court might carefully consider the proposition that the statute should begin to run at the time when the patient acquires knowledge, or by the use of reasonable diligence should acquire knowledge, of the true source of his trouble.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, containing copy submitted by Hartley F. Peart, Esq., has been established by the California Medical Association Council. Each issue will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

SPECIAL ARTICLES

PROPOSED CALIFORNIA LAWS: HAVING RELATIONSHIPS TO PUBLIC HEALTH AND MEDICAL PRACTICE*†

As Submitted in the January, 1937, Period of the
Fifty-Second Session of the California
Legislature

Board of Health
(Fifteen Bills)

General

A. B. 2532, by Donihue (referred to Committee on Governmental Efficiency and Economy). Relating to organization, powers, and duties of Department.

Crippled Children

A. B. 1308, by Laughlin (referred to Committee on Public Charities and Correction). Amending Sections 2979b and 2979c.

S. B. 569, by Slater (referred to Committee on Education), amending School Code.

S. B. 607, by Schottky (referred to Committee on Social Security). Care, treatment, etc., physically defective and handicapped persons.

Miscellaneous

A. B. 1014, by Lyon (referred to Committee on Public Health and Quarantine), relating to canned tomatoes.

A. B. 1251, by Tenney (referred to Committee on Public Health and Quarantine), relating to sterilization of bottles and containers.

A. B. 1252, by Tenney (referred to Committee on Public Health and Quarantine), relating to sanitation of canneries.

A. B. 1253, by Tenney (referred to Committee on Public Health and Quarantine). Misbranding of drugs.

A. B. 1334, by Muldoon (referred to Committee on Manufactures), relating to adulterating, misbranding, false advertising and sale of foods.

A. B. 2143, by Call (referred to Committee on Public Health and Quarantine). Sterilization of containers.

A. B. 2182, by Voigt (by request) (referred to Committee on Public Health and Quarantine). Fumigation of containers.

A. B. 2676, by Patterson (referred to Committee on Public Health and Quarantine). Pollution of waters.

A. B. 2718, by Glick (referred to Committee on Public Health and Quarantine). Pollution of waters.

A. B. 2723, by Lyon (referred to Committee on Public Health and Quarantine). Sterilization of used containers.

A. B. 2724, by Lyon (referred to Committee on Public Health and Quarantine). Preservation, care and display of foods.

Chiropody

(Two Bills)

A. B. 1171, by Gannon (referred to Committee on Medical and Dental Laws), relating to advertising.

A. B. 1173, by Gannon (referred to Committee on Medical and Dental Laws). Companion bill to A. B. 1171.

Chiropractors

(One Bill, One Constitutional Amendment)

A. B. 2731, by Reeves (referred to Committee on Medical and Dental Laws), amending Sections 3, 4, 5, 6, 7, 9, 10, 12, 16, 17, and 19 of the Initiative Act.

A. C. A. 35, by Reeves (referred to Committee on Constitutional Amendments). Proposed amendment to Article IV of Constitution by adding Section 25¼, relating to the practice of chiropractic.

* This list was compiled by the Committee on Legislation and Public Policy of the California Medical Association, Dr. Junius B. Harris, Chairman, in conjunction with the Public Health League of California, Ben H. Read, Executive Secretary.

† See also editorial comment on page 145.

Clinical Laboratories

(One Bill)

S. B. 118, by Parkman (referred to Committee on Public Health and Quarantine). Similar to 1935 bill.

Codes

(Nine Bills)

A. B. 880, by Gannon (referred to Committee on Judiciary—General), establishing Business and Professions Code.

A series of codes introduced by McGovern and all referred to Committee on Public Health and Quarantine:

S. B. 132—Medical Code

S. B. 134—Dental

S. B. 288—Nursing

S. B. 289—Trained Attendants

S. B. 290—Medical Library

S. B. 291—Blindness at Childbirth

S. B. 253, by Nielsen (referred to Committee on Governmental Efficiency), relating to Department of Professional and Vocational Standards.

S. B. 254, by Nielsen (referred to Committee on Governmental Efficiency). Companion bill to S. B. 253.

Compensation Act

(Eight Bills)

A. B. 2011, by Burns, Hugh M. (referred to Committee on Insurance). Adds Section 4600, repeals Sections 4601 and 4602.

Patients' Records

A. B. 384, by Clark, Lore, Peek, Hawkins, Hornblower, and Pelletier (referred to Committee on Hospitals and Asylums). Records to be exhibited to patient and to any person authorized in writing by patient to examine same. Applies to compensation cases.

A. B. 385, by Clark, Peek, Hornblower, Lore, Pelletier, Hawkins, and Rosenthal (referred to Committee on Hospitals and Asylums). Companion bill to A. B. 384.

Medical Treatment

A. B. 488, by Boyle (referred to Committee on Medical and Dental Laws). Skeleton bill.

A. B. 643 by Clark (referred to Committee on Insurance), amending Section 9 of Act relating to right of an employee to select anyone licensed to treat the type of injury he has sustained.

A. B. 644, by Clark (referred to Committee on Insurance). Companion bill to A. B. 643.

A. B. 2236, by Rosenthal (referred to Committee on Insurance), adding Section 9.5 relating to treatment of injuries.

A. B. 2249, by Flint (referred to Committee on Insurance). Adding paragraph (a½) to Section 9, relating to medical treatment.

County Hospitals

(Three Bills, One Constitutional Amendment)

A. B. 51, by Heisinger (referred to Committee on County Government). Refer to copy of bill.

A. B. 1196, by Turner (referred to Committee on Governmental Efficiency and Economy). Refer to copy of bill.

A. B. 1695, by Turner (referred to Committee on Hospitals and Asylums). Refer to copy of bill.

S. C. A., by Crittenden (referred to Committee on Constitutional Amendments). Refer to copy of bill.

Dental Practice Act

(Twenty-two Bills)

A. B. 489 and A. B. 493, by Boyle, skeleton bills (referred to Committee on Medical and Dental Laws).

A. B. 609, 610, 611, 612, by Dawson, skeleton bills (referred to Committee on Medical and Dental Laws).

A. B. 724, 725, 726, 727, by Dawson, skeleton bills (referred to Committee on Medical and Dental Laws).

A. B. 1258, by Cronin (referred to Committee on Medical and Dental Laws), relating to suspension and revocation of dental licenses.

A. B. 1259, by Cronin (referred to Committee on Medical and Dental Laws), relating to dental hygienists.

A. B. 1260, by Cronin (referred to Committee on Medical and Dental Laws), relating to the practice of dentistry.

A. B. 1261, by Cronin (referred to Committee on Medical and Dental Laws), relating to registration of licenses with county clerks.

A. B. 1929, by Garibaldi (referred to Committee on Medical and Dental Laws), relating to appointment of members of State Board of Dental Examiners.

A. B. 2266, by Hunt (referred to Committee on Medical and Dental Laws). Amends Section 12 of Dental Practice Act, relating to unprofessional conduct.

A. B. 2267, by Hunt (referred to Committee on Medical and Dental Laws). Companion Bill to A. B. 2266.

A. B. 2453, by McMurray (referred to Committee on Medical and Dental Laws). Amends Section 13 of Dental Practice Act, relating to suspension and revocation of licenses.

A. B. 2454, by McMurray (referred to Committee on Medical and Dental Laws), relating to unprofessional conduct.

A. B. 2586, by Cronin (referred to Committee on Medical and Dental Laws), relating to the practice of dentistry.

A. B. 1262, by Cronin (referred to Committee on Governmental Efficiency and Economy). Amends Section 372 of Political Code, relating to State Board of Public Health.

S. B. 1021, by Williams (referred to Committee on Public Health and Quarantine). Adds to Section 13a to the Dental Practice Act, relating to places of practice.

Dental Advertising

(Two Bills)

A. B. 845, by Cassidy (referred to Committee on Medical and Dental Laws). Deletes reference to advertising professional superiority or the advertising to perform services in a superior manner.

A. B. 2604, by Laughlin (referred to Committee on Medical and Dental Laws). Amends Sections 11 and 13, relating to advertising.

Reciprocity

(Dental: One Bill)

S. B. 243, by Seawell (referred to Committee on Public Health and Quarantine). Amends Sections 6 and 7, relating to the qualifications and examination of applicants.

Expert Testimony

(Two Bills)

S. B. 446, by McGovern (referred to Committee on Judiciary). Refers to compensation for expert testimony. C. M. A. bill.

S. B. 593, by Olson (referred to Committee on Judiciary), relating to reasons for opinion.

Health Insurance

(Five Bills)

A. B. 1283, by Welsh (referred to Committee on Insurance). Identical with Williams Bill, S. B. 121.

A. B. 1491, by Cronin, McMurray, and Boyle (referred to Committee on Medical and Dental Laws). C. M. A. bill. Refer to copy of bill.

S. B. 121, by Williams (referred to Committee on Insurance). Refer to copy of bill.

S. B. 605, by McGovern (referred to Committee on Public Health and Quarantine). C. M. A. bill. Refer to copy of bill.

S. B. 886, by Nielsen (referred to Committee on County Government). Relates to life, health and accident insurance for county employees.

Hospitalization and Insurance

(Nine Bills)

A. B. 936, by Cronin (referred to Committee on Insurance), amending Insurance Code, relating to nonprofit hospital service insurance.

A. B. 937, 938, 1132, by Cronin (referred to Committee on Hospitals and Asylums), relating to nonprofit hospital service plans.

A. B. 1640, 1641, by Gannon (referred to Committee on Hospitals and Asylums), relating to nonprofit hospital service plans.

A. B. 2160, by Voight (referred to Committee on Public Charities and Corrections). Provides hospitalization and financial aid for mothers and expectant mothers.

S. B. 142 and 143, by McColl (referred to Committee on Governmental Efficiency and Committee on Insurance, respectively). Provides hospitalization and hospital insurance for state employees.

Injunctions

(One Bill)

A. B. 1783, by Gannon (referred to Committee on Judiciary, General). Adds Section 114 to the Business and Professions Code, relating to injunctions.

Insurance

(Two Bills)

A. B. 547, by Donnelly (referred to Committee on Insurance). Relates to disability insurance.

A. B. 2423, by Desmond (referred to Committee on Insurance). Companion bill to Nielsen's S. B. 886, relating to insurance for county employees.

Insane

(Twenty Bills)

A. B. 619, by Lyon (referred to Committee on Judiciary—Codes), relating to arrest and detention.

A. B. 651, by Tenney (referred to Committee on Crime Problems), relating to alienists.

A. B. 791, by Redwine (referred to Committee on Public Charities and Corrections). Liability of estates of psychopathic parole patients for maintenance.

A. B. 930, by Dannenbrink (referred to Committee on Hospitals and Asylums), relating to discharge of patients from State institutions.

A. B. 1025, by Tenney (referred to Committee on Crime Problems), relating to sanity of defendant in a criminal prosecution.

A. B. 1045, by Welsh (referred to Committee on Judiciary—General), relating to procedure in the trial and release of the criminally insane.

A. B. 1368, by Clark, Scudder, and Peek (referred to Committee on Prisons and Reformatories). To provide for special treatment for insane and feeble-minded prisoners.

A. B. 1447, by Gannon and others (referred to Committee on Hospitals and Asylums). Appropriation for construction of a neuropsychopathic hospital.

A. B. 1540, by Rosenthal (referred to Committee on Hospitals and Asylums). Sterilization of inmates of State hospitals for insane.

A. B. 1834, by Lyon and Latham (referred to Committee on Judiciary—General). Relates to persons mentally disordered and bordering on insanity but not dangerously insane.

A. B. 1844, by Lyon (referred to Committee on Judiciary—General), relating to persons mentally disordered or otherwise incompetent.

A. B. 2148, by Williamson (referred to Committee on Judiciary—Codes), relating to guardians of insane or incompetent persons.

A. B. 2709, by Daley (referred to Committee on Social Service and Welfare). Relates to Department of Institutions.

A. B. 2710, by Daley (referred to Committee on Hospitals and Asylums), relating to uniforms of patients in State hospitals for insane.

S. B. 353, by Holohan and Allen (referred to Committee on Prisons and Reformatories). To provide special treatment of insane and feeble-minded prisoners.

S. B. 512, by Quinn and others (referred to Committee on Military Affairs). Appropriation for construction of a neuropsychopathic hospital.

Alcoholics

A. B. 1932 and 1933, by Dannenbrink (referred to Committee on Public Morals).

Inebriates

A. B. 2313, by Cunningham, Clark, Watson, and Miss Miller (referred to Committee on Public Morals). Care and treatment of inebriates.

Private Psychopathic Institutions

A. B. 2147 by Williamson (referred to Committee on Hospitals and Asylums).

Itinerant Vendors of Drugs

(Seven Bills)

A. B. 716, by Patterson (referred to Committee on Public Health and Quarantine). Licenses.

A. B. 743, by Fulcher (referred to Committee on Public Health and Quarantine). Licenses.

A. B. 744, by Fulcher (referred to Committee on Judiciary—General). Licenses.

S. B. 386 and 387, by Tickle (referred to Committee on Revenue and Taxation). Licenses.

S. B. 637 and 638, by Jespersen and Garrison (referred to Committee on Revenue and Taxation). Licenses.

Medical Practice Act

(Thirty-Three Bills)

A. B. 158 to 167, inclusive, skeleton bills by Voigt (referred to Committee on Medical and Dental Laws).

A. B. 494 and 495, skeleton bills by Boyle (referred to Committee on Medical and Dental Laws).

A. B. 598 and 599 and 603 to 608, inclusive, skeleton bills by Dawson (referred to Committee on Medical and Dental Laws).

A. B. 1004 and 1005 and 1006 and 1008, bills by Gannon (referred to Committee on Medical and Dental Laws). Apparently introduced by osteopaths.

A. B. 1015 and 1016, by Lyon (by request) (referred to Committee on Soldiers and Sailors Affairs). Refer to copies of bills.

A. B. 1319 and 1320, by Gannon (referred to Committee on Medical and Dental Laws). Relate to unlawful use of degrees and unprofessional conduct.

S. B. 781, 782, 783, by McGovern (referred to Committee on Public Health and Quarantine). Remedies and disciplinary proceedings under Medical Practice Act.

Advertising

S. B. 497, by Fletcher (referred to Committee on Governmental Efficiency). Relates to advertising. California Medical Association bill from San Diego County Medical Society.

S. B. 731, by Fletcher (referred to Committee on Public Health and Quarantine). Companion Bill to S. B. 497.

Naturopaths

(One Bill)

A. B. 1472, by Pelletier (referred to Committee on Medical and Dental Laws). Creates Board of Naturopathic Examiners independent of Board of Medical Examiners, etc.

Narcotics

(Eight Bills)

S. B. 8, 18, 19, 58, 59, 62, 98, 237, all by Young, relating to changes and amendments.

Nursing

(Two Bills)

A. B. 2125, by Dannenbrink (referred to Committee on Medical and Dental Laws). Amends Nursing Act, relating to the exemption of certain schools of nursing and of graduates thereof, conducted by certain universities or colleges, from certain provisions of said Act.

S. B. 673, by Nielsen (referred to Committee on Finance). Appropriation for Bureau.

Optometry

(Nine Bills)

A. B. 1137 to 1143, inclusive, by Cronin and Boyle (referred to Committee on Medical and Dental Laws).

A. B. 2349 and 2350, by Reeves (referred to Committee on Medical and Dental Laws).

Pharmacy and Drugs

(Fifty-Nine Bills)

A. B. 1014, 1253, 1340, 1859; A. B. 1952 to 2003, inclusive; A. B. 2619; A. B. 2620.

S. B. 38, S. B. 372.

Prophylactics

(One Bill)

A. B. 1721, by Boyle (referred to Committee on Medical and Dental Laws).

Radio Advertising

(Two Bills)

A. B. 288, by Gilbert (referred to Committee on Judiciary—Codes).

S. B. 785, by Olson (referred to Committee on Judiciary).

Schools

(Six Bills)

Health and Development Certificates to Osteopaths

A. B. 684, by Daley (referred to Committee on Public Health and Quarantine).

A. B. 1880, by Clark (referred to Committee on Education).

Hearing and Sight Tests (Audiometers)

A. B. 812 and A. B. 1676, by Miss Miller (referred to Committee on Education).

Physical Examination of Pupils

A. B. 1630, by Laughlin (referred to Committee on Education).

School Nurses

S. B. 314, by Cunningham (referred to Committee on Education).

Silicosis

(One Bill)

A. B. 2029, by Fulcher (referred to Committee on Insurance).

Venereal Diseases

(Two Bills)

A. B. 1089, by Beene, Cottrell, Boyle, Morgan, Turner, Welsh, Patterson, Cronin, Robertson, Dawson, Maloney, Clark, Peek, McMurray, and Hunt (referred to Committee on Public Health and Quarantine). Establishes State Bureau of Venereal Diseases Under Direction Board of Health. Appropriates \$200,000.

A. B. 2569, by Richie (referred to Committee on Medical and Dental Laws).

Veterinary Medicine

(Two Bills)

A. B. 1265 and 1266, by Corwin (referred to Committee on Judiciary—General).

Vital Statistics

(Four Bills)

Death Certificates—A. B. 803, A. B. 1237, and S. B. 507.

Birth Certificates—S. B. 48.

X-Rays

(One Bill)

A. B. 1009, by Boyle (referred to Committee on Medical and Dental Laws). Pacific Roentgen Club Bill. Refer to copy of bill.

Miscellaneous

(Thirteen Bills)

Abortions—A. B. 2264 and 2265, by Hunt.

Blood Grouping Tests—A. B. 2116, by Redwine.

Prevention of Cruelty to Animals—A. B. 2770, by Millington; S. B. 943, by Jespersen.

Eugenics—A. B. 2589, by Johnson and Morgan; A. B. 2590, by Johnson and Hornblower.

Health Inspection of Immigrants—A. B. 2115, by Redwine.

Hospital, Medical, and Nursing Facilities on Vessels—A. B. 418, by Robertson.

Interference with Delivery of Medical Supplies—S. B. 649, by Knowland.

Medical Attention for Prisoners—A. B. 885, by Flint.

Medical Kits on Common Carriers—A. B. 2112, by Hawkins (by request).

Medical Library—A. B. 2599, by Johnson. Kress Bill.

ROSTER OF CALIFORNIA LEGISLATURE

Following the custom of former years, the names of the Legislators who make up the California Senate and California Assembly are given for the information and convenience of component county societies, their committees on public policy and legislation and for members of the California Medical Association. In all matters having to do with proposed laws, members are requested to make it a rule to consult with and act through their local county society officers and committees, who in turn will communicate with their State Committee. In that way the possibilities for confusion or misunderstanding will be greatly minimized. The Legislature will be in session again by the time this issue of CALIFORNIA AND WESTERN MEDICINE is placed in the mails, and as changes take place in the status of proposed public health laws component societies will be kept informed.—Ed.

The maps and lists are taken from the January 4, 1937, Bulletin of the Los Angeles Chamber of Commerce.

STATE OFFICERS

Governor	Frank F. Merriam (R)	State Capitol, Sacramento
Lieutenant Governor	George J. Hatfield (R)	333 Montgomery Street, San Francisco
Secretary of State	Frank C. Jordan (R)	State Capitol, Sacramento
Controller	Ray L. Riley (R)	State Capitol, Sacramento
Treasurer	Charles G. Johnson (R)	State Capitol, Sacramento
Attorney General	U. S. Webb (R)	State Building, San Francisco
Superintendent of Public Instruction	Dr. Walter F. Dexter	Library and Courts Buildings, Sacramento

UNITED STATES SENATORS

Hiram W. Johnson (R), Mills Tower, San Francisco	William Gibbs McAdoo (D), Transamerica Bldg., Los Angeles
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REPRESENTATIVES IN CONGRESS

DISTRICT	COVERING	REPRESENTATIVE AND PARTY	CALIFORNIA ADDRESS*
First	Assembly Districts 1, 7, part of 3, 4, and part of 5.....	Clarence F. Lea (D).....	719 North St., Santa Rosa
Second	Assembly Districts 2, part of 3 and 6.....	Harry L. Englebright (R).....	Nevada City
Third	Assembly Districts part of 3, part of 5, 8, 9, 11 and 12.....	Frank H. Buck (D).....	Vacaville
Fourth	Assembly Districts 20, 22, 27 and 28.....	F. R. Havenner (Prog.).....	460 Ellis St., San Francisco
Fifth	Assembly Districts 21, 23, 24, 25 and 26.....	Richard J. Welch (R).....	978 Guerrero St., San Francisco
Sixth	Assembly Districts 10, 13, 14 and 15.....	Albert E. Carter (R).....	552 Montclair Ave., Oakland
Seventh	Assembly Districts 16, 17, 18 and 19.....	John H. Tolan (D).....	1007 Harvard Road, Oakland
Eighth	Assembly Districts 29, 30, 31, 34 and part of 35.....	John J. McGrath (D).....	280 Crystal Springs Rd., San Mateo
Ninth	Assembly Districts 32, 33, 36, 37 and part of 38.....	B. W. Gearhart (R).....	857 "M" St., Fresno
Tenth	Assembly Districts 39, 40, 41, part of 35 and part of 38.....	Henry E. Stubbs (D).....	707 E. Cypress St., Santa Maria
Eleventh	Assembly Districts 42, 43, 47 and 48.....	John Steven McGroarty (D).....	Rancho Chupa Rosa, Tujunga
Twelfth	Assembly Districts 49, 50, 51 and 53.....	H. Jerry Voorhis (D).....	End of Valley Center, San Dimas
Thirteenth	Assembly Districts 45, 52, 54 and 56.....	Charles Kramer (D).....	1947 N. Serrano Ave., Los Angeles
Fourteenth	Assembly Districts 44, 55, 62 and 64.....	Thomas F. Ford (D).....	940 N. Benton Way, Los Angeles
Fifteenth	Assembly Districts 57, 58, 63 and 65.....	John M. Costello (D).....	2142 Canyon Drive, Hollywood
Sixteenth	Assembly Districts 46, 59, 60 and 61.....	John F. Dockweiler (D).....	935 S. Dunsmuir Ave., Los Angeles
Seventeenth	Assembly Districts 66, 67 and 68.....	Charles J. Colden (D).....	2200 Alma St., San Pedro
Eighteenth	Assembly Districts 69, 70 and 71.....	Byron N. Scott (D).....	42D—59th Place, Long Beach
Nineteenth	Assembly Districts 72, 73, 74, 75 and 76.....	Harry R. Sheppard (D).....	Box 465, Yucaipa
Twentieth	Assembly Districts 77, 78, 79 and 80.....	Ed V. Izac (D).....	5380 El Cajon Drive, San Diego

STATE SENATORS

(Senators from even-numbered districts were elected in 1934; from odd-numbered districts have just been elected in 1936. Senators are chosen for the term of 4 years. Constitution of California, Article IV, Section 4.)

DISTRICT	COVERING	SENATOR AND PARTY	RESIDENCE ADDRESS*
First	Modoc, Lassen and Plumas Counties.....	Harold J. Powers (R).....	Eagleville
Second	Del Norte, Siskiyou Counties.....	James M. Allen (D).....	Yreka
Third	Humboldt County.....	Irwin T. Quinn (D).....	2205 "H" St., Eureka
Fourth	Mendocino and Lake Counties.....	George M. Biggar (R).....	Covello
Fifth	Shasta and Trinity Counties.....	John B. McColl (R).....	1702 Placer St., Redding
Sixth	Butte County.....	Charles H. Deuel (D).....	119 Broadway, Chico
Seventh	Sierra, Nevada and Placer Counties.....	Jerrold L. Seawell (R).....	303 Mariposa St., Roseville
Eighth	Tehama, Glenn and Colusa Counties.....	D. Jack Metzger (R).....	641 Main St., Red Bluff
Ninth	Eldorado, Amador and Alpine Counties.....	A. L. Pierovich (D).....	31 Sutter St., Jackson
Tenth	Sutter and Yuba Counties.....	W. P. Rich (R).....	424 Fifth Ave., Marysville
Eleventh	Yolo and Napa Counties.....	Frank L. Gordon (R).....	Gordon Valley, P. O. Suisun
Twelfth	Sonoma County.....	Herbert W. Slater (D).....	800 Fourth St., Santa Rosa
Thirteenth	Marin County.....	Thomas F. Keating (D).....	640 Lincoln Ave., San Rafael
Fourteenth	San Francisco County.....	Walter McGovern (R).....	625 Market St., San Francisco
Fifteenth	Solano County.....	Thomas McCormack (R).....	Rio Vista
Sixteenth	Alameda County.....	William F. Knowland (R).....	806 Grand Ave., Alameda
Seventeenth	Contra Costa County.....	T. H. DeLap (R).....	2616 Sonoma Ave., Richmond
Eighteenth	Santa Clara County.....	Sanborn Young (R).....	Los Gatos

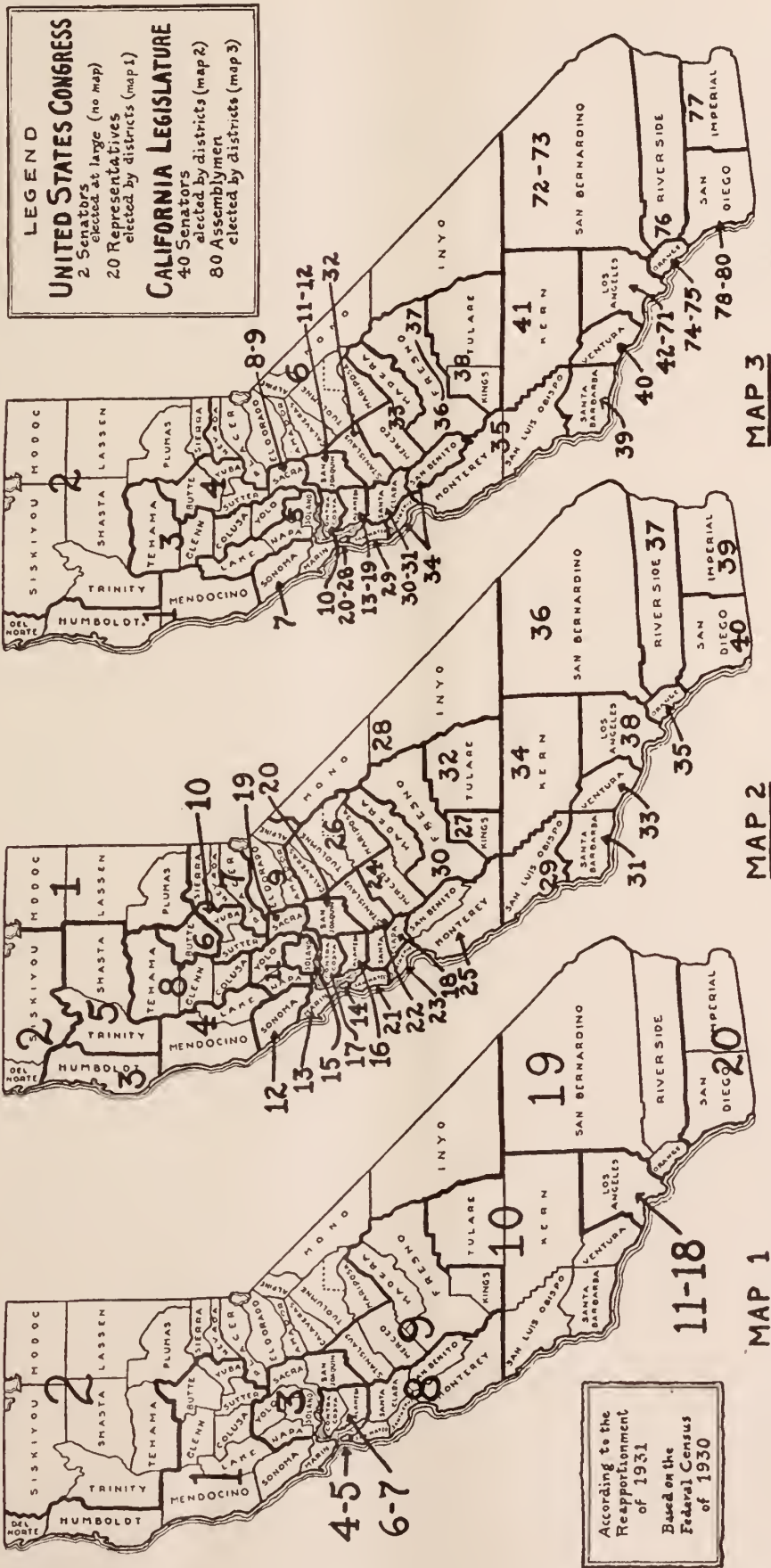
* Federal Senators and Congressmen may be addressed either U. S. Senate or U. S. House of Representatives, Washington, D. C.; State Senators, California Senate Chamber, Sacramento; State Assemblymen, Assembly Chamber, Sacramento.

CALIFORNIA'S POLITICAL DISTRICTS

CONGRESSIONAL

SENATORIAL

ASSEMBLY



DISTRICT	COVERING	SENATOR AND PARTY	RESIDENCE ADDRESS*
Nineteenth	Sacramento County	Roy J. Nielsen (R)	615 Twenty-first St., Sacramento
Twentieth	San Joaquin County	Bradford S. Crittenden (R)	Bank of America Bldg., Stockton
Twenty-first	San Mateo County	Harry L. Parkman (R)	934 Rosewood Drive, San Mateo
Twenty-second	Stanislaus County	J. C. Garrison (D)	Route 1, Box 1826, Modesto
Twenty-third	Santa Cruz County	James B. Holohan (D)	123 Pacheco Ave., Santa Cruz
Twenty-fourth	Merced and Madera Counties	Andrew R. Schottky (R)	Shaffer Bldg., Merced
Twenty-fifth	San Benito and Monterey Counties	Edward H. Tickle (R)	Highlands Inn, Carmel
Twenty-sixth	Calaveras, Tuolumne and Mariposa Counties	Dan E. Williams (R)	Sonora
Twenty-seventh	Kings County	R. R. Cunningham (D)	1201 N. Irwin St., Hanford
Twenty-eighth	Mono and Inyo Counties	Karl P. Keough (D)	Bishop
Twenty-ninth	San Luis Obispo County	Chris N. Jespersen (R)	Atascadero
Thirtieth	Fresno County	Ray W. Hays (R)	Brix Bldg., Fresno
Thirty-first	Santa Barbara County	J. James Hollister (D)	Gaviota
Thirty-second	Tulare County	Frank W. Mixter (R)	303 E. Palm St., Exeter
Thirty-third	Ventura County	James J. McBride (D)	1647 Poli St., Ventura
Thirty-fourth	Kern County	J. I. Wagy (R)	1909 Second St., Bakersfield
Thirty-fifth	Orange County	Harry C. Westover (D)	1527 E. Fourth St., Santa Ana
Thirty-sixth	San Bernardino County	Ralph E. Swing (R)	313 Central Bldg., San Bernardino
Thirty-seventh	Riverside County	John Phillips (R)	65 N. Fourth St., Banning
Thirty-eighth	Los Angeles County	Culbert L. Olson (D)	639 S. Spring St., Los Angeles
Thirty-ninth	Imperial County	Edward H. Law (D)	634 Hamilton St., El Centro
Fortieth	San Diego County	Ed Fletcher (R)	335 Walnut St., San Diego

STATE ASSEMBLYMEN

(Assemblymen are elected biennially and serve for the period of one legislative session of 2 years. Constitution of California, Article IV, Section 3. The Fifty-second session of the Legislature is the third session to be elected under the reapportionment worked out by the Legislature of 1931.)

DISTRICT	COVERING	ASSEMBLYMAN AND PARTY	RESIDENCE ADDRESS*
First	Del Norte, Humboldt and Mendocino Counties	Michael J. Burns (R)	1644 Summer St., Eureka
Second	Siskiyou, Trinity, Modoc, Shasta, Lassen, Plumas and Sierra Counties	Clinton J. Fulcher (R)	Lookout
Third	Tehama, Glenn, Colusa and Yolo Counties	John H. O'Donnell (D)	118 First St., Woodland
Fourth	Butte, Yuba and Sutter Counties	Seth Millington (D)	Gridley
Fifth	Napa, Solano and Lake Counties	Ernest C. Crowley (D)	Suisun
Sixth	Nevada, Placer, Eldorado, Amador, Alpine, Calaveras, Tuolumne, Mariposa, Mono and Inyo Counties	Jesse M. Mayo (R)	Angels Camp
Seventh	Sonoma and Marin Counties	Hubert B. Scudder (R)	506 S. Main, Sebastopol
Eighth	Part of Sacramento County	Chester F. Gannon (D)	3543 "H" St., Sacramento
Ninth	Part of Sacramento County	Earl D. Desmond (D)	2022 Twenty-second St., Sacramento
Tenth	Contra Costa County	Harold F. Sawalisch (D)	437 Fifteenth St., Richmond
Eleventh	Part of San Joaquin County	Charles M. Weber (R)	329 E. Miner Ave., Stockton
Twelfth	Part of San Joaquin County	James E. Thorp (R)	Lockeford
Thirteenth	Part of Alameda County	James M. Cassidy (D)	1520 Eighty-ninth Ave., Oakland
Fourteenth	Part of Alameda County	George P. Miller (D)	1808 Encinal Ave., Alameda
Fifteenth	Part of Alameda County	Leon M. Donihue (D)	2841 Kingsland Ave., Oakland
Sixteenth	Part of Alameda County	Arthur H. Breed, Jr. (R)	91 Wildwood Gardens, Piedmont
Seventeenth	Part of Alameda County	Henry P. Meehan (D)	646 Forty-second St., Oakland
Eighteenth	Part of Alameda County	Henry A. Dannenbrink (D)	715 Easton Bldg., Oakland
Nineteenth	Part of Alameda County	Gardiner Johnson (R)	2201 Rose St., Berkeley
Twentieth	Part of San Francisco County	Thomas A. Maloney (R)	330 Texas St., San Francisco
Twenty-first	Part of San Francisco County	Joseph Francis Sheehan (D)	111 Genebern Way, San Francisco
Twenty-second	Part of San Francisco County	Kennett B. Dawson (R)	1124 Leavenworth St., San Francisco
Twenty-third	Part of San Francisco County	Wm. B. Hornblower (R)	1530 Guerrero St., San Francisco
Twenty-fourth	Part of San Francisco County	Patrick J. McMurray (D)	3918 26th St., San Francisco
Twenty-fifth	Part of San Francisco County	Melvin L. Cronin (R)	350 Laguna Honda Blvd., San Francisco
Twenty-sixth	Part of San Francisco County	Ray Williamson (R)	756 Page St., San Francisco
Twenty-seventh	Part of San Francisco County	Jefferson E. Peyser (R)	1955 Broadway, San Francisco
Twenty-eighth	Part of San Francisco County	Edgar C. Levey (R)	2040 Lake St., San Francisco
Twenty-ninth	San Mateo County	Harrison W. Call (R)	734 Miller Ave., So. San Francisco
Thirtieth	Part of Santa Clara County	Adron A. Beene (R)	American Trust Bldg., Palo Alto
Thirty-first	Part of Santa Clara County	C. C. Cottrell (R)	256 South 17th St., San Jose
Thirty-second	Stanislaus County	Hugh P. Donnelly (D)	114 Lyons Ave., Turlock
Thirty-third	Merced and Madera Counties	James D. Garibaldi (D)	443 Twenty-second St., Merced
Thirty-fourth	Santa Cruz and San Benito Counties	Jacoh M. Leonard (R)	470 Hawkins St., Hollister
Thirty-fifth	Monterey and San Luis Obispo Counties	Ellis E. Patterson (elected by "write-in" process)	King City
Thirty-sixth	Part of Fresno County	Hugh M. Burns (D)	2055 San Joaquin St., Fresno
Thirty-seventh	Part of Fresno County	S. L. Heisinger (D)	Route 4, Box 90E, Fresno
Thirty-eighth	Kings and Tulare Counties	Gordon H. Garland (D)	Woodlake
Thirty-ninth	Santa Barbara County	Alfred W. Robertson (D)	1524 Dover Road, Santa Barbara
Fortieth	Ventura County	Fred P. Muldoon (D)	400 "E" St., Oxnard
Forty-first	Kern County	Rodney L. Turner (D)	1117 Jefferson St., Delano
Forty-second	Part of Los Angeles County—Newhall, Palmdale, Lancaster and San Bernardino Valley	Elmer E. Lore (D)	11743 Hamlin St., North Hollywood
Forty-third	Part of Los Angeles County—Burbank and Glendale	C. Don Field (R)	1552 N. Ridgeway Drive, Glendale

* Federal Senators and Congressmen may be addressed either U. S. Senate or U. S. House of Representatives, Washington, D. C.; State Senators, California Senate Chamber, Sacramento; State Assemblymen, Assembly Chamber, Sacramento.

DISTRICT	COVERING	ASSEMBLYMAN AND PARTY	RESIDENCE ADDRESS*
Forty-fourth	Los Angeles County—Downtown Los Angeles City	John B. Pelletier (D)	248 S. Olive St., Los Angeles
Forty-fifth	Los Angeles County—Eastside L. A. City and Bairdstown	Charles D. Hunt (D)	4122 Berenice Ave., Los Angeles
Forty-sixth	L. A. County—Palisades del Rey, El Segundo, Inglewood, Hawthorne, Manhattan, Hermosa, Redondo Beaches	Jack B. Tenney (D)	724 E. Fairview Blvd., Inglewood
Forty-seventh	Los Angeles County—Pasadena City	Eleanor Miller (R)	251 S. Oakland Ave., Pasadena
Forty-eighth	L. A. County—Pasadena City, La Canada, Sierra Madre	Frank G. Martin (R)	745 Sacramento St., Altadena
Forty-ninth	L. A. County—Monrovia, Azusa, Glendora, Pomona	Frank L. Baynham (D)	2150 N. San Antonio Ave., Pomona
Fiftieth	L. A. County—Covina, El Monte, West Covina, Whittier	Gerald C. Kepple (R)	634 Caldwell Ave., Whittier
Fifty-first	L. A. County—Belvedere, Montebello, East Los Angeles	William Moseley Jones (D)	113 N. 21st St., Montebello
Fifty-second	L. A. County—Vernon, Huntington Park, Maywood, Bell, Cudahy, etc.	Ben Rosenthal (D)	1926 E. Fourth St., Los Angeles
Fifty-third	L. A. County—South Pasadena, San Marino, San Gabriel, Alhambra and Monterey Park	E. V. Latham (R)	504 N. Second St., Alhambra
Fifty-fourth	L. A. County—Highland Park and Eagle Rock sections Los Angeles City	Wilbur F. Gilbert (D)	3537 The Paseo, Los Angeles
Fifty-fifth	L. A. County—Los Angeles City, 7th St. to Maple to Exposition, Hoover, Washington, Westmoreland Sts.	Frank D. Laughlin (D)	2675 San Marino St., Los Angeles
Fifty-sixth	L. A. County—East Hollywood section Los Angeles City	Thomas J. Cunningham (R)	3065 Tyburn St., Los Angeles
Fifty-seventh	L. A. County—Hollywood from Western to Fairfax north of Beverly Blvd. in Los Angeles City	Kent H. Redwine (R)	3340 Durand Drive, Hollywood
Fifty-eighth	L. A. County—Beverly Blvd., Vermont Ave. and Washington St., Victoria and Rimpau, in L. A. City	Frank J. Waters (R)	1163 Fourth Ave., Los Angeles
Fifty-ninth	L. A. County—West Hollywood and Beverly Hills	Charles W. Lyon (R)	1052 S. Redondo Blvd., Los Angeles
Sixtieth	L. A. County—Santa Monica, Soldiers' Home, Brentwood, Pacific Palisades	Geoffrey F. Morgan (R)	478 24th St., Santa Monica
Sixty-first	L. A. County—Venice, Mar Vista, Culver City, Palms	Ernest O. Voigt (D)	3651 Cardiff Ave., Los Angeles
Sixty-second	L. A. County—Los Angeles City, Maple Ave. to 9th St. to Alameda, Slauson and Main Sts.	Augustus F. Hawkins (D)	821 E. 24th St., Los Angeles
Sixty-third	L. A. County—Los Angeles City, Washington Blvd. to Hoover, Santa Barbara and Angeles Mesa	Ralph Louis Welsh (D)	2011 Eighth Ave., Los Angeles
Sixty-fourth	L. A. County—Los Angeles City, Hoover to Sunset, Figueroa to Seventh St.	Samuel W. Yorty (D)	465½ S. Lake St., Los Angeles
Sixty-fifth	L. A. County—Los Angeles City, Santa Barbara to Main to Slauson, Crenshaw to Leimert Blvd.	Gene Flint (D)	314 W. 55th St., Los Angeles
Sixty-sixth	L. A. County—Los Angeles City, Slauson, Central to Manchester to Van Ness Ave.	James J. Boyle (D)	1918 W. 73rd St., Los Angeles
Sixty-seventh	L. A. County—Gardena, Green Meadows, Shoestring to 190th St., part of Los Angeles City	Cecil R. King (D)	1754 E. Florence Ave., Los Angeles
Sixty-eighth	L. A. County—Part of Los Angeles City, San Pedro, Wilmington, Palos Verdes Estates and Shoestring south of 190th Street, Catalina and San Clemente Islands	Fred Reeves (D)	583 Eighth St., San Pedro
Sixty-ninth	L. A. County—South Gate, Lynwood, Compton, Downey, Hynes, Bellflower, Artesia and Norwalk	Fred P. Glick (D)	5155 Tweedy Abbott Road, South Gate
Seventieth	L. A. County—East part of City of Long Beach, Signal Hill	John Gee Clark (D)	45 Geneva Walk, Long Beach
Seventy-first	L. A. County—West part of City of Long Beach	Paul Peek (D)	2363 Pine Ave., Long Beach
Seventy-second	Part of San Bernardino County—Chino, Ontario, Upland, Cucamonga, Etiwanda and San Bernardino Township	Godfrey A. Andreas (D)	515 West 17th St., Upland
Seventy-third	Part of San Bernardino County not included in 72nd	Gordon W. Corwin (R)	259 Pacific Ave., Highland
Seventy-fourth	Part of Orange County—1st, 4th and 5th Supervisorial Districts as of January 1, 1931	Clyde A. Watson (D)	273 N. Harwood St., Orange
Seventy-fifth	Part of Orange County, not included in 74th	Thomas H. Kuchel (R)	315 S. Claudina St., Anaheim
Seventy-sixth	Riverside County	Nelson S. Dilworth (R)	119 N. Buena Vista St., Hemet
Seventy-seventh	Imperial County	Clarence R. Walker (R)	Westmoreland
Seventy-eighth	Part of San Diego County—Portion of San Diego City	Jeanette E. Daley (D)	4231 Witherby St., San Diego
Seventy-ninth	Part of San Diego County—Remainder of San Diego City	Paul A. Richle (D)	4264 Menlo Ave., San Diego
Eightieth	Part of San Diego County—Outside of San Diego City	Charles W. Stream (R)	P. O. Box 21, Palm City

* Federal Senators and Congressmen may be addressed either U. S. Senate or U. S. House of Representatives, Washington, D. C.; State Senators, California Senate Chamber, Sacramento; State Assemblymen, Assembly Chamber, Sacramento.

BILL [WILLIAMS] NOT HEALTH INSURANCE*

By CHESTER H. ROWELL, LL.D.

Officials of a number of credit unions in the San Francisco district are reported to have voted to favor a bill, drafted by Attorney Leo Shapiro and to be introduced in the Legislature by State Senator Dan Williams, which they understood would enable the 40,000 credit-union members in California and all others desiring it, to "obtain voluntary medical and hospital insurance." Since they want this insurance, they naturally looked with approval on a measure which they supposed would provide it.

* * *

If, however, they had examined the draft bill more carefully, they would have discovered that it provides for no "insurance" whatever, "voluntary" or otherwise. The only thing resembling "insurance" in it is that it is under the supervision of the Insurance Commissioner. By that argument, liquor regulation would be tax equalization, since it is administered by the Board of Equalization. Otherwise there is no insurance in the bill, not even in its title, which is the "Voluntary Health Service Act." "Service" is not "insurance," even if it is paid for on the installment plan. What this bill provides for is "contract medicine."

* * *

Even as a "contract medicine" measure the bill has some extraordinary provisions. "A" physician, licensed in California, may go into the business of furnishing medical, hospital and nursing services wholesale, for weekly or monthly fees, and may open branch offices and hire other physicians, surgeons, and nurses, to work under him, as well as making such arrangements as he can with hospitals, by which he (not the hospitals) shall provide hospital service, but there is no provision by which a group or partnership of physicians may do so. It is "a" physician and his hired doctors.

* * *

Even the provision of hospital services is confined to "a" physician, who presumably owns no hospital. The hospitals cannot go into the contract hospital business, on their own, and are dependent on such organization as "a" physician may get up. He will collect the fees from his customers, and will presumably pay the hospital from them. However, the only "reserve" he is required to keep is a half-month's fees, plus the unearned portion of current fees. This would be wholly inadequate if any considerable number of his customers (they are, in this aspect, not "patients") should need serious hospital attention at once.

* * *

What services "the" physician and his hired men shall render the patient is not specified in the law. He is merely authorized to contract for "such medical services of a specified nature" as may be required, and to file with the Insurance Commissioner a copy of his contracts, setting forth "the nature of the medical services to be rendered" and whether, and under what terms and conditions hospitalization and nursing will be furnished. This opens the way to the worst abuses that have grown up under unregulated voluntary health insurance corporations, some of which have almost limited surgical services to fractures of the left tibia, caused by being run over by the right rear wheel of a pink street car, south of Market street, between 8 and 8:30 p. m., in the dark of the moon.

* * *

The duties of the Insurance Commissioner are confined largely to issuing licenses to "a" physician making application in due form; receiving reports showing how many customers the physician has, how much he charges and how much he receives; collecting one per cent of gross fees for the license, and appointing a "medical deputy" who shall be his "adviser," and shall have some sort of vague authority over the standards of services rendered. The licensee shall hire enough doctors to bear a proper

ratio to the number of patients; shall have a half-month's fees on deposit, and shall not draw out the next month's fees except in proportion to the number of days that have expired of the month. There is no other reserve.

* * *

The bill, of course, lacks every feature that would make it a health insurance act, good or bad, and it does nothing for the practice of medicine except to put it on a basis like that of towel service in office buildings, plus the fact that it is paid for on the installment plan. The only part of health service that would be practical on any such plan is hospitalization, and the hospitals are excluded from this, except as they may turn it over to "a" physician, if they can make arrangements with him. Group medicine is also reduced to "a" physician and his hired men. There is no adequate supervision, legal, administrative or medical, and the patient must find out for himself whether there are any jokers in his contract.

* * *

"A" physician engaging in this business on a wholesale scale, with the authorized "branch offices," will, of course, have to employ runners, to drum up business, and to show that he offers more services for less money than his competitor across the street. The Insurance Commissioner cannot prescribe or enforce a standard contract.

If California is going to have health insurance (as nearly all civilized countries have long had it), let it have the real thing.

This bill is not even good "contract medicine."—From the *San Francisco Chronicle*, September 17, 1936.

CALIFORNIA STATE VENEREAL DISEASE BUREAU ESTABLISHED

In August of 1917 the California State Board of Health established a Bureau of Venereal Diseases through the provision of emergency funds by the Governor of California. This bureau operated efficiently until 1920, when its activities were discontinued because of a lack of funds and lack of public interest.

The bureau established by the California State Board of Health in 1917 was the first state bureau of venereal diseases to be established in the country. The war emergency was largely responsible for its organization, which was made possible at that time through the use of federal funds devoted to the purpose.

There is now a civic awakening to the importance of venereal disease control, and through the provisions of the Social Security Act, funds have been made available by the Federal Government which will enable the State Department of Public Health to reestablish its Bureau of Venereal Diseases.

The reestablishment of this bureau, supported by public opinion, will enable the coordination and regulation of activities for the control of syphilis that are now being carried on by the various clinics in medical schools and health departments scattered throughout the State. Under the Social Security Act, funds are disbursed through the State Health Officer, it being necessary for him to submit a budget and plan which meet the approval of the Surgeon-General of the United States Public Health Service.

The main objectives in the present plan for venereal disease control consist of: (a) The provision of adequate facilities for diagnosis and treatment of syphilis; (b) Post-graduate instruction for physicians in the management and control of syphilis; (c) Education of the general public in all matters pertaining to venereal diseases and their control; (d) Stimulation of case reporting and the provision of adequate supervision over active cases of syphilis; (e) Intensive and complete investigations of early and potentially infectious cases of syphilis and their contacts.

In order to facilitate the Department's activities in the control of venereal diseases, new regulations were adopted by the State Board of Public Health on January 2, 1937. These regulations are as follows*:

"It shall be the duty of every person who gives treatment for syphilis or gonorrhea to report in writing immediately to the local health officer within whose juris-

*Article by Chester H. Rowell, Esq., refers to Senate Bill 121 (Williams) and its duplicate Assembly Bill 1283 (Welsh).

* See also news item, on page 200.

diction such patient is, on a card supplied by the State Department of Public Health, the patient's initials, sex and date of birth.

"The local health officer shall forward these reports to the State Department of Public Health at least weekly.

"The physician shall keep a record by name and address of each patient treated.

"The name and address of the patient shall be reported to the local or state health official to whom the attending physician is required to report such case, upon the special request of such official if in his judgment this may be necessary to prevent the spread of the disease to other persons.

"Whenever any person suffering from syphilis or gonorrhea shall discontinue treatment while, in the judgment of the attending physician, he is capable of transmitting the disease to others, such physician shall report immediately such facts, together with the patient's initials and date of birth to the local or state health official to whom the attending physician is required to report such case.

"Records of any local department of health or of any local health officer or of any laboratory, clinic or other institution relating to cases of syphilis or gonorrhea shall be confidential except in so far as may be necessary to carry out the provisions of the law and these regulations."

In order that adequate facilities and efficient methods of treatment may be made available, basic requirements for the conduct of clinics, both as to equipment and methods of procedure, are made. A state-wide survey is now being undertaken for the purpose of developing and adopting uniform standards in the conduct of clinics.

Through the use of National Social Security funds allotted to the California State Department of Public Health, the following services will be made available:

1. Public health nurses to do follow-up field work in order that patients who begin treatment may continue without lapses which are common in patients suffering from these diseases.

2. Distribution of arsenical and bismuth preparations to be used in the treatment of patients who are unable to pay for these supplies and the provision of suitable literature.

3. The provision, in so far as may be possible, for a special short course in social hygiene and venereal disease control for public health nurses at the universities.

In general, the plan for venereal disease control formulated by Surgeon-General Parran while serving as State Health Commissioner of New York will be followed. Each early case of syphilis, which means one in which the infection is of less than one year's duration, will be investigated, locally, and diligent efforts will be made to identify the contacts of each early case, both prior and subsequent to infection. Individuals so identified will be examined and placed under treatment as required.

Each potentially infectious syphilis case, which means all untreated cases in which the infection is of two years or less duration and all treated cases in which the required course has not been completed, will be investigated, locally, and the contacts of such case following infection will be identified, examined and placed under treatment as required. These requirements do not apply to cases under the care of a private physician.

Delinquent cases in the local community will be investigated. Each patient, reported as having discontinued treatment for more than seven days while capable of transmitting the disease, will be sought, and, if found, will be returned to treatment, using such measures as may be necessary.

The National Social Security Act, therefore, makes possible immediate action in the control of venereal diseases, and the California program in the prevention and control of syphilis is already under way.

Dr. Malcolm H. Merrill, in charge of the Syphilis Clinic at the University of California School of Medicine, is the Chief of the Bureau of Venereal Diseases of the California State Department of Public Health. Doctor Merrill is a graduate of the St. Louis University School of Medicine and has spent three years in research work at the Rockefeller Institute of Medical Research, New York City. The appointment of Doctor Merrill was announced by Dr. Walter M. Dickie, Director of the California State Department of Public Health.

SMOKE AND FUMES CLEANSSED BY SUPER-SOUND WAVE IN PROCESS DEVELOPED BY BUREAU OF MINES

The United States Department of the Interior, through its Bureau of Mines, sends out the following bulletin:

Dense clouds of fumes threatening the greenery and freshness of a countryside, subdued at the shriek of a whistle! Columns of choking smoke darkening the skies of teaming cities cleansed at the command of a sound wave! Precious particles of gold, silver, lead, copper, and zinc, bound skyward from the smelter stack, knocked out of the fume and collected as valuable byproducts! Fragments of unburned coal and ash, belched from factory chimneys, bent on soiling the housewife's linen or smirching the surface of fresh paint, diverted from its malignant course at the behest of a "supersonic wave" that may be of such high pitch that you cannot even hear it.

Such is the promise of a device invented by H. W. St. Clair, metallurgist, United States Bureau of Mines, which will be demonstrated in the North Interior Building, Washington, D. C., Saturday, February 13, at 10 a. m. The device should be of real aid in solving the smelter-fume problem, which has for years been the source of expensive litigation due to suits brought by property owners charging damage to vegetation, live stock, and water supplies. The device should also be of value in helping to curb the smoke nuisance in large cities, which has been responsible for injury to property and health running into many millions of dollars annually.

It has long been known that, when sound waves are passed through a tube containing a fine powder, the powder will be concentrated at points that are free from vibratory motion. It has also been known that waves of extremely high frequency affected the diffusion of solid or liquid particles in a gas. However, as the Bureau of Mines points out, no practical application has previously been made of this knowledge.

The St. Clair method merely passes the smoke or fume through a tube in which standing sound waves are established. These standing waves are produced by so adjusting the length of the tube that waves reflected from the upper end are in phase with the original sound waves set up at the lower end.

In order that the process may work at its best, the wavelength used must be approximately equal to the diameter of the tube. For a tube of practicable diameter, this means that the frequencies used will vary from 3 to 20 kilocycles per second. A person of acute hearing can detect waves of frequencies up to about 5 kilocycles; those of greater frequency are above the auditory range and hence are sometimes called "supersonic."

To generate sound waves of this frequency, several types of equipment may be used. Mr. St. Clair has used what is technically known as the magneto-strictive method, but for purposes of popular demonstration, an acoustic generator is used. This, in fact, is merely a shrill whistle. The sound waves produced by the whistle are reflected in phase with the original waves from the top of the tube and cause the solid particles to fall out of the gas stream. The action is similar to the effect produced by drawing the bow of a violin over a metal plate on which dust particles are deposited, when the vibrations cause the particles to arrange themselves in groups.

The Bureau of Mines for many years past has been interested in the problem of smelter fumes. As long ago as 1929 it began work on the possibility of settling smoke by means of acoustic waves.

The installation of the process that has now been devised should be comparatively inexpensive, as it utilizes simple sound waves instead of the more elaborate processes employed in other fume-treatment methods, and is, therefore, adaptable to the smaller plants.

Patents covering the new process will be applied for by members of the staff of the Bureau of Mines for the benefit of the public.

The process will be demonstrated at the annual meeting of the American Institute of Mining and Metallurgical Engineers in New York next week, the demonstration in Washington being a preview for officials of the Department of the Interior.

UNITED STATES SOCIAL SECURITY ACT: TITLES VIII AND IX

Obligations of Employers and Employees*

Under the provisions of the Federal Social Security Act, approved August 14, 1935 (49 Stat. 620), the Bureau of Internal Revenue is made responsible for collecting the taxes imposed by that Act. Two taxes are imposed by Title VIII, and one tax by Title IX, of the Act. Liability for the Title VIII taxes is determined under the provisions of Title VIII. Similarly, liability for the Title IX tax is determined under the provisions of Title IX. The provisions of either title are inapplicable to any tax imposed by the other title.

The taxes imposed under Title VIII became effective on January 1, 1937, and will be administered by the Miscellaneous Tax Unit of the Bureau. The tax imposed under Title IX became effective as of January 1, 1936, and is being administered by the Income Tax Unit of the Bureau. It is the purpose of this mimeograph to call to your attention the principal provisions of Titles VIII and IX of the Act, which affect persons subject to the taxes imposed thereby.

TITLE VIII

Section 801, Title VIII, of the Social Security Act, imposes an income tax upon every employee measured by the amount of "wages" received by him on and after January 1, 1937, with respect to "employment" on and after such date. Section 802(a) of the Act requires that this tax shall be collected by the employer of the taxpayer by deducting the amount thereof from the wages as and when paid. The employer is made liable for the payment of this tax whether or not it is collected from the employee.

Section 804, Title VIII, of the Social Security Act, imposes an excise tax upon every employer (irrespective of the number of individuals employed), measured by the amount of "wages" paid by him on and after January 1, 1937, with respect to "employment" on and after such date. Each tax under Title VIII is imposed at the following rates:

1. With respect to employment during the calendar years 1937, 1938, and 1939, the rate shall be 1 per cent.
2. With respect to employment during the calendar years 1940, 1941, and 1942, the rate shall be 1½ per cent.
3. With respect to employment during the calendar years 1943, 1944, and 1945, the rate shall be 2 per cent.
4. With respect to employment during the calendar years 1946, 1947, and 1948, the rate shall be 2½ per cent.
5. With respect to employment after December 31, 1948, the rate shall be 3 per cent.

The terms "wages" and "employment," for the purposes of Title VIII, are defined in Section 811 of the Act as follows:

"(a) The term 'wages' means all remuneration for employment, including the cash value of all remuneration paid in any medium other than cash; except that such term shall not include that part of the remuneration which, after remuneration equal to \$3,000 has been paid to an individual by an employer with respect to employment during any calendar year, is paid to such individual by such employer with respect to employment during such calendar year.

"(b) The term 'employment' means any service of whatever nature, performed within the United States by an employee for his employer, except—

1. Agricultural labor;
2. Domestic service in a private home;
3. Casual labor not in the course of the employer's trade or business;
4. Service performed by an individual who has attained the age of sixty-five;
5. Service performed as an officer or member of the crew of a vessel documented under the laws of the United States or of any foreign country;
6. Service performed in the employ of the United States Government or of an instrumentality of the United States;

* See also news item in this issue, "When Employer Voluntarily Pays Employees' Tax," on page 202. The Editor prints this non-medical information because it may be of interest and importance to many members.

7. Service performed in the employ of a state, a political subdivision thereof, or an instrumentality of one or more states or political subdivisions;

8. Service performed in the employ of a corporation, community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual."

Under the provisions of Section 11 of the Carriers Taxing Act, approved August 29, 1935 (49 Stat. 974), service performed as an employee of a carrier, or as a representative of such employees, within the meaning of that Act, are also excepted from "employment" as that term is used in Title VIII.

Detailed regulations under Title VIII which will contain provisions explaining its application (including provisions with respect to records to be kept, the method of paying the taxes, etc.), for the guidance of internal revenue officers and employees, taxpayers, and other interested persons, are in the course of preparation. It is expected that such regulations will be promulgated well in advance of January 1, 1937, the date the taxes become effective. When promulgated, copies of the regulations will be made available at the offices of collectors of internal revenue.

TITLE IX

Section 901, Title IX, of the Social Security Act imposes an excise tax upon employers with respect to having eight or more individuals in their employ on each of some twenty days during the taxable year, each such day being in a different calendar week equal to the following percentages of the total wages payable by them with respect to employment during the calendar year indicated:

- "1. With respect to employment during the calendar year 1936 the rate shall be 1 per cent;
2. With respect to employment during the calendar year 1937 the rate shall be 2 per cent;
3. With respect to employment after December 31, 1937, the rate shall be 3 per cent."

The tax applies only with respect to services performed by employees within the United States, and the following services are excepted:

- "1. Agricultural labor;
2. Domestic service in a private home;
3. Service performed as an officer or member of the crew of a vessel on the navigable waters of the United States;
4. Service performed by an individual in the employ of his son, daughter, or spouse, and service performed by a child under the age of twenty-one in the employ of his father or mother;
5. Service performed in the employ of the United States Government or of an instrumentality of the United States;
6. Service performed in the employ of a state, a political subdivision thereof, or an instrumentality of one or more states or political subdivisions;
7. Service performed in the employ of a corporation, community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual."

The measure of the tax is the total amount of remuneration paid or payable by employers to their employees with respect to employment during the calendar year.

Under Section 902 of the Act, taxpayers are entitled to credit against the tax imposed by Section 901 of the Act, contributions made by them, with respect to services not excepted by Title IX of the Act, during the taxable year (before the date of filing their returns for the taxable year) into an unemployment fund under the laws of a state which has been certified by the Social Security Board to the Secretary of the Treasury. The total credit may not exceed 90 per cent of the tax imposed by Section 901 of the Act. The credit will not be allowed unless the taxpayer files the proof of credit provided by Article 212 of Regulations 90, promulgated with respect to the taxing provisions of Title IX of the Act.

Every employer subject to the provisions of Title IX of the Act is required to file a return on Form 940 on or before the thirty-first day of January, following the close of the calendar year with the collector of internal revenue for the district in which is located the principal place of business of the employer, and if the employer has no principal place of business in the United States the return must be filed with the collector of internal revenue at Baltimore, Maryland. The Commissioner may extend the time for filing the return for a period not to exceed sixty days from the date prescribed by law for filing the return. By Article 304 of Regulations 90 authority to grant extensions of time for filing returns has been delegated to the various collectors of internal revenue and such extensions will be granted in the same manner and under the same conditions as are applicable in the case of income tax returns. Applications for such extensions should be made to the collector of internal revenue for the district in which the employer files his returns.

The tax computed on the return is due and payable on the thirty-first day of January following the close of the calendar year, but the taxpayer may elect to pay such tax in four equal installments. If the taxpayer elects to pay the tax in four installments, one-fourth of the tax is due and payable on January 31, April 30, July 31, and October 31, respectively, following the close of the calendar year. An extension of time not to exceed six months from the date prescribed for the payment of the tax or any installment thereof may be granted by the Commissioner under such rules and regulations as he may prescribe with the approval of the Secretary of the Treasury.

Inquiries concerning Title VIII of the Act should refer to the number of this mimeograph and the symbols MT:SS, and inquiries concerning the taxing provisions of Title IX of the Act and Regulations 90 should refer to the number of this mimeograph and the symbols IT:RR.

Persons desirous of information in regard to provisions of the Act other than those relating to taxes are referred to the following agencies:

Old-age assistance, aid to dependent children, and aid to the blind; unemployment compensation; old-age benefits; Titles I, II, III, IV, VII, and X and Sections 903, 904, and 910 of Title IX of the Social Security Act: Bureau of Informational Service, Social Security Board, Washington, D. C.

Maternal and child-health services, services for crippled children, and child-welfare services; Title V, Parts 1, 2, 3, and 5, of the Social Security Act: Children's Bureau, Department of Labor, Washington, D. C.

Public-health work; Title VI of the Social Security Act: Bureau of Public Health Service, Department of the Treasury, Washington, D. C.

Vocational rehabilitation; Title V, Part 4, of the Social Security Act: Office of Education, Department of the Interior, Washington, D. C.

GUY T. HELVERING,
Commissioner.

THE CAMPAIGN AGAINST SYPHILIS

Greater progress will be made in 1937 than in any year since the World War in the campaign to stamp out syphilis and reduce the widespread prevalence of gonorrhea in the United States, it was confidently predicted recently by Dr. William F. Snow, General Director of the American Social Hygiene Association.

Important factors, Doctor Snow pointed out, are the funds available for this purpose to the United States Public Health Service and the Children's Bureau through the Social Security Act, and the changed attitude of newspapers and popular magazines which are now making possible the education of the general public through frank scientific and reassuring discussion.

Doctor Snow's comment was made as he left for Washington, D. C., to participate in the three-day Conference on Venereal Disease Control, December 28 to 30, called by Dr. Thomas Parran, Surgeon-General of the United States Public Health Service. He praised Doctor Parran warmly for making syphilis the next great point of attack in public health protection for the nation.

"It is conservatively estimated, said Doctor Snow, "that about six million men, women, and children throughout the nation are infected with syphilis, although not one in ten is under treatment by a licensed physician; and the amount of gonorrhea is more than twice as great. This minimum is maintained from year to year by new cases which thus far offset reductions through cure of patients. It is especially tragic that the age group in which the largest number of infections occur is between sixteen and thirty.

"Aside from the naturally appealing reasons for stamping out syphilis, such as the physical handicaps and suffering, the emotional distress, economic burdens, and the broken homes to which it is related, there is also a staggering tax load that can be traced to this disease. Thousands of its sufferers—their personal funds exhausted, and treatment delayed until their hearts or other organs have been damaged—are in free hospital wards or being cared for by visiting nurse organizations; additional thousands lose their sight and receive state blind relief pensions; many more thousands are admitted to institutions for the insane. If all fatalities actually due to syphilis were reported as such, very probably it would be found the leading cause of death in the United States.

"The persistent activities of such agencies as the American Social Hygiene Association and its affiliated and co-operating societies have supplemented the efforts of health departments and the medical and nursing professions to build a practical program for the control of venereal diseases. This has been accomplished; and it remains only to secure the necessary state and local appropriations, and sustained public interest, to insure steady progress in the conquest of syphilis and the treatment and control of gonorrhea."

Doctor Snow disclosed that plans are being made for the holding of simultaneous regional conferences in about twenty-five large cities, and meetings in smaller cities and rural areas throughout the country, on February 3, 1937, which has been designated as "National Social Hygiene Day." The American Social Hygiene Association, 50 West Fiftieth Street, New York City, is serving as the clearing house for data, ideas, and suggestions for anyone who may be interested.

Federal, state, and local health officials are collaborating with the Association and other voluntary agencies in utilizing these meetings to focus attention on the vital syphilis problem more extensively than ever before. Among the groups participating, in addition to the medical and public health professions, are a great number of welfare, educational, religious and civic organizations, such as the National Society for the Prevention of Blindness, National Organization for Public Health Nursing, National Tuberculosis Association, National Committee for Mental Hygiene, National Probation Association, National Council of Women, General Federation of Women's Clubs, Federal Council of Churches of Christ in America, and so on.

"The progress of these regional conferences, and the meetings in smaller communities," said Doctor Snow, "will be centered largely about the findings of the Surgeon-General's Conference on Venereal Disease Control. The scientific methods of accurate diagnosis and treatment for syphilis are known; but we must see that this knowledge is used for the benefit of the millions who need it, and for the protection of the rest of the population who are not yet infected."

Regulations for Public and Private Sanatoriums.—According to a law passed by the French senate and chamber of deputies recently, every sanatorium for the treatment of pulmonary tuberculosis will be obliged to possess grounds which will suffice to permit the patients to take walks without leaving the premises under control of the institution. Such an area will be in proportion to the number of beds in the sanatorium. A private sanatorium cannot be opened without special permission of the government. This applies also to any changes in construction and increase in the number of beds. Tuberculous patients whose sanatorium costs are paid by the social insurance authorities can be treated only in institutions that are regularly licensed and not indiscriminately in any villa, hotel, boarding house or private resort.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. X, No. 3, March, 1912

From Some Editorial Notes:

Do Men Think?—Do such prominent men as William J. Mayo, George W. Crile, A. J. Ochsner, J. H. Carstens, E. Fletcher Ingalls, and others, who contributed articles to the January number of the *American Journal of Surgery*, give the slightest thought to what they are doing by so contributing? It would seem to be impossible that men of that character, men who have worked as hard as a number of these gentlemen have worked for the up-building of the American Medical Association can really understand what it means when they give their support to a publication that represents the very extreme of "published for profit" medical (?) journalism. The advertising pages of the publication in question are full of the very worst fake and fraudulent nostrum advertisements that ever were. And yet men of distinction in the medical world will help that nefarious business along by contributing articles to such a sheet! The *Journal of the American Medical Association*, in December last [December, 1911], called attention to the nostrums advertised in the publication under discussion and deplored the fact that reputable men would contribute articles to such a publication or subscribe to it. And that is the gist of the whole matter. . . .

The Press and Patent Medicine.—We howl a lot about the outrageousness of the newspapers in printing advertisements of quacks, cancer cures and patent medicines of all sorts, but are we very much better than they? Look through the advertising pages of the *New York Medical Journal*, the *Medical Record*, the *Annals of Surgery*, for example, and see what you think is the difference between our own publication and the daily press! There is mighty little, when you come to study it. . . .

Quality of Papers.—At various times, during the past ten years, there has been some discussion as to the quality of the scientific papers published in the *State Journal*. The comment of the editor has always been that the papers published in the official *Journal* reflect the productivity of the physicians in the State and their attitude toward their fellows in the State and toward the *State Journal*. . . . It all comes back to the original contention—the *State Journal* is just what the members of the Society make it. If they write and contribute good papers, then the scientific tone of the *Journal* is good; if they do not do this, then it is lower than it should be. Let us always have criticism, for it is good for anyone; but let us also be sure that we understand what we are criticizing and why. It is up to the members of the Society.

Publicity Campaign.—Probably only a few even of those who are deeply interested in the American Medical Association have any very clear idea of the enormous amount of work directly affecting the medical profession and the public that the Association is doing. This particular word of comment relates to only one of the various large and important activities of the Association—its press bureau for the education of the public on public health matters. . . .

Notice Preliminary Program.—Forty-second annual meeting of the Medical Society of the State of California. Del Monte Hotel, Del Monte, April 16, 17, and 18, 1912. Railroad rates the same as usual; one and one-third fare for the round trip. . . .

(Continued in Front Advertising Section, Page 17)

†This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

Board Proceedings

At a regular meeting of the Board of Medical Examiners held at Independent Foresters' Hall, 1329 South Hope Street, Los Angeles, February 8 to 11, inclusive, the following changes in the status of licentiates were made:

Edward H. Anthony, Los Angeles, placed on probation for three years without narcotic privileges.

Robert V. Baker, Los Angeles, guilty of violation of probation; penalty deferred until the July meeting.

James H. Beggs, Oakland (conviction, Pacific Coast Abortion Ring), license revoked.

Francis James Bold, Montebello, license restored and placed on probation for five years.

Samuel D. Burgeson, Jr., Los Angeles, placed on probation for five years without narcotic privileges.

John E. Cummings, Los Angeles, dismissed without prejudice.

Merton E. Eastman, Oakland, placed on probation for three years.

Thomas Flint, Redding, license revoked.

James Harvey Johnston, San Francisco, placed on probation for five years without narcotic privileges.

John Lenz, Redondo Beach, license restored and placed on probation for five years.

Ramon Lopez, Brawley, license restored and placed on probation for five years without narcotic privileges.

Leroy J. Otis, Norwalk, guilty; placed on probation for five years without narcotic privileges.

Allen H. Peek, Ventura, guilty; placed on probation for five years without narcotic privileges.

Byron H. Pelton, Compton, license restored and placed on probation for five years without narcotic privileges.

Jesse C. Ross, San Francisco (conviction, Pacific Coast Abortion Ring), license revoked.

Alfred Henry Valentine St. John, Los Angeles (conviction, Pacific Coast Abortion Ring), license revoked.

Leo Morton Schulman, Los Angeles, license revoked.

Henry C. Wallace, Fresno, guilty; placed on probation for five years without narcotic privileges.

George E. Watts, Los Angeles (conviction, Pacific Coast Abortion Ring), license revoked.

Glenn Granger White, San Diego, guilty; license revoked.

Carlisle B. Wiley, Los Angeles, license revoked.

News

"X-ray negatives, although paid for by patients, are the property of physicians. Municipal Judge Alfred J. Fritz so ruled yesterday in an unique case brought against Dr. Robert A. Ostroff by two patients, S. M. Wilzen and his wife, Peggy. 'It is a matter of common knowledge that x-ray negatives are practically meaningless to the layman. Their retention by the physician or surgeon constitutes an important part of his clinical record,' held Judge Fritz, denying Mr. and Mrs. Wilzen possession of x-rays taken by Doctor Ostroff." (*San Francisco Examiner*, February 12, 1937.)

"The United States Circuit Court of Appeals in San Francisco refused jurisdiction in the case of three naturopaths of Hawthorne, California, who were seeking to halt enforcement of the California Medical Practice Act. Arthur O., Ray, and Jack Borland brought suit first in the State court against Los Angeles County officials and officers of Inglewood Township, asking that they be enjoined from enforcing the Act and from refusing to permit them

(Continued in Front Advertising Section, Page 23)

†The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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IF YOU will but turn that over in your mind, there will come a recognition of the reasons why Baxter's are so famous. Baxter was the pioneer. Baxter's straddled its job and rode it hard. . . . Made its name world famed, because it gave to physicians perfect solutions . . . solutions as correct and as uniform and as fine as they would have made them themselves had they the time and the surety and Baxter's modern laboratories. Baxter's was first and Baxter's have always been first in all things pertaining to intravenous therapy. Baxter's, the pioneer, are perfect solutions in perfect dispensing containers.



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Your delinquent accounts be-
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Send them to your Bureau
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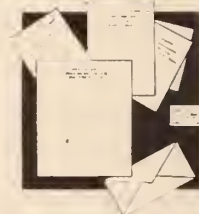
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Cibalgine Used to Relieve Pope's Pain.—Last January 19, Pope Pius was said to be in a dangerous condition and suffering from excruciating pain. Powerful sedatives were used at first; then fearing the effects of morphin on the Pope's weakened heart, his physician administered Cibalgine, a sedative produced by Ciba Company, Inc., of New York.

Prior to the use of Cibalgine, the pain had increased in frequency and intensity. Newspapers reported that when the new drug (Cibalgine) was administered, it was believed to have relieved the pain.

Hoarseness and Cancer.—The symptom of hoarseness is present whenever the function of the vocal cords is interfered with in any manner. It may denote simply a mild laryngitis or it may be the result of a severe involvement of the larynx by tuberculosis, syphilis, or a malignant growth.

The intensive campaign for the education of the public concerning the importance of the early detection of cancer should not overlook stressing hoarseness, since of all locations within the body, the larynx gives warning of a growth during its earliest stage. Particularly is this true of intrinsic or chordal carcinoma, a type of malignancy which, when removed before it has extended to involve extralaryngeal tissue, is a curable disease.

The profession generally is aware of the significance of hoarseness as an early sign of laryngeal cancer. It is our duty to impress upon our patients the necessity of investigation by a certified laryngologist as soon as this symptom appears. Schwartz rightly states that "if these principles are practiced many preventable deaths will be avoided." Hoarseness. Editorial from *New York State Journal of Medicine*, August 1, 1936.

It has been said that the foundation of health is proper feeding. In its broader aspect the proper feeding of children revolves around the public recognition of the dependence of humans upon the dairy cow. The white race cannot survive without dairy products.—*Health Digest*.



POTENT PRODUCTS



THE NATIONWIDE campaign to control venereal disease is receiving valuable publicity from many sources. The final results of the campaign, however, will depend upon the effectiveness of the products used and the proper supervision of all cases.

It is generally agreed that efficient treatment requires the administration of an arsenical and a heavy metal, alternately and continuously, for a period of from twelve to eighteen months. For this purpose Squibb has available two outstanding preparations—Neoarsphenamine and Iodobismitol with Saligenin.

Neoarsphenamine Squibb is designed to produce maximum therapeutic results. It is noted for its high stability, chemical uniformity, rapid solubility, brilliantly clear solution, low toxicity and high spirocheticidal power. Equally effective

for the conditions in which their use is indicated are Arsphenamine Squibb and Sulpharsphenamine Squibb.

Iodobismitol with Saligenin provides all the systemic effects of bismuth in the treatment of syphilis. It presents bismuth in anionic (electro-negative) form. It is slowly and completely absorbed and slowly excreted, thus providing a relatively prolonged bismuth effect. Repeated injections are well tolerated in both early and late syphilis.

Iodobismitol with Saligenin is a propylene glycol solution containing 6 per cent sodium iodobismuthite, 12 per cent sodium iodide and 4 per cent saligenin (a local anesthetic).

. . .

For literature address the Professional Service Department, 745 Fifth Avenue, New York City.

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Liver Therapy

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Accredited by the American Medical Association and Approved by the American College of Surgeons. Open to all members of the California Medical Association. Accredited School of Nursing and Out-Patient Department.

Vitamin Advertising and the Mead Johnson Policy. The present spectacle of vitamin advertising running riot in newspapers and magazines and via radio emphasizes the importance of the physician as a controlling agent in the use of vitamin products.

Mead Johnson & Company feel that vitamin therapy, like infant feeding, should be in the hands of the medical profession, and consequently refrain from exploiting vitamins to the public.

Adding Life to One's Years.*—The average length of life has been consistently rising for centuries and has been rapidly increasing for several decades. How high will it go? How high can it go? The health enthusiast seems to think that there is no limit to attainment in this direction and confidently expects to see it go beyond sixty years, even beyond seventy years. He points out this and that "preventable" cause of death and takes another whack at the shins of the Grim Reaper—who merely grins and bides his time. So long as one can be healthy and happy, interested and interesting, all of this is well enough, and we may look with keen anticipation toward the time when the life of man may be long upon the earth.

Obviously, however, not much more can be done toward lengthening life. As it is now we have hardly, if at all, stretched the span, but have merely brought up the average by saving the lives of babies and children—a most worth while endeavor, to be sure. At present a child who dies after a few weeks cuts down the average as much as half a dozen men or women living to the age of seventy can raise it. Shall we then admit that those who are responsible for the health of the community and the race shall rest upon their laurels and be content to try the far less romantic task of merely holding the ground that has been won at so great an effort? As a matter of fact we have only begun the much more important task

(Continued on Page 33)

* By Thurman B. Rice, M. D.

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Get acquainted with the G-E man in your locality. You'll find him a reliable source of information and technical service, always interested in your continued satisfaction as a G-E user.

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When you refer a patient to M. J. Benjamin you are assured that a support will be carefully made according to sound principles backed by two generations of experience.

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Superintendent

(Continued from Page 36)

of enriching life. Much has been done, but the task of enriching life—unlike that of lengthening life—is one of infinite possibilities. There must of necessity be a limit to length, but there can be no limit to the fullness and the quality of human existence. And so we propose a new goal. *Not so much that we may add years to our life, but that we may add life to our years.*

In large measure the tenets of orthodox health philosophy are tiresome and forbidding. As a rule the public yawns during the health talk. Children are bored by the cautious spinster—male or female, married or single—who instructs them in the quest for vitamins and red corpuscles. Those portions of the population who pay much attention to such lore are in real danger of becoming cranks, neurotics, and all together acute-pains-in-the-neck.

Valetudinarianism is by no means a rare disease in this country and time, and is rapidly becoming a really serious health problem. Already there are millions of people who in attempting to secure their personal comfort and safety succeed only in remembering how miserable they are. They have been taught to be afraid of overeating, under-eating, overexertion, lack of exercise, and a score of other dangers real and imaginary; they are afraid to bear children; they are afraid to smile for fear it will make wrinkles; afraid to work for fear of "domestic hands"; afraid to get up a sweat for fear of "B. O."; afraid to live for fear they will die. It is time to pay more attention to life and less to the technique of living. It is time to begin putting the "living" back into healthy living. It is time to sit up to the table and eat an honest meal with less fussing about vitamins and calories. Vitamins and calories are of importance, to be sure, but they are being overemphasized.

We greatly need a new philosophy of life and health. Health is not an end in itself—at least it should not be. It is a means to an end! I need health in order that I may take care of my family, do my work, and not irk my fellow men too seriously. Otherwise the state of my health

(Continued on Page 41)



MULFORD POLLEN EXTRACTS

FOR the diagnosis and treatment of hay fever patients, the Mulford Biological Laboratories of Sharp & Dohme offer a complete Hay Fever Service. Mulford Pollens Dried and Pollen Extracts include practically all pollens of first importance in the United States and Canada, and meet practically all seasonal and geographical demands. This extensive assortment of pollens is offered in a variety of packages for both diagnosis and treatment, to meet the physician's requirements in his particular community.

Mulford pollen preparations are botanically true to label, being prepared from mature pollens specifically identified. They are freshly prepared and standardized and will retain their full



strength through the dating period.

For Diagnosis. Mulford Pollens Dried are supplied in tube-vials of 50 mgm. Mulford Pollen Extracts are supplied for the scratch test in concentrated form (50,000 pollen units per cc.) in convenient capillary tube-points sufficient for one test; for the intradermal test, in 2-cc. ampoule-vials (2,000 pollen units per cc.).

For treatment. Mulford Pollen Extracts are supplied in Graduated Dose Treatment Packages in syringes or vials, and in 5-cc. vials of 2,000 and 20,000 pollen units per cc.

Write for the informative booklet, "Hay Fever Therapy," thoroughly discussing principles and methods of diagnosis and treatment.



"For the Conservation of Life"

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very good taste, sir*



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Fly Your Patients!**Emergency Air Ambulance
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STANDARD FOR BLOODPRESSURE**W. A. BAUM CO. INC. NEW YORK****SINCE 1916 ORIGINATORS AND MAKERS OF
BLOODPRESSURE APPARATUS EXCLUSIVELY**

(Continued from Page 38)

is of no great consequence to anyone except to myself. We must remind ourselves that it is better to enjoy a short vacation than to endure a long one. My mother once bought at a bargain sale a whole bolt of calico. She was overjoyed, and made herself two or three dresses from it. Then there were nightgowns, curtains, pillowcases, napkins—all from the same bolt of goods. She got so tired of the pattern that she finally gave the remainder of it away. Too much calico! One remembers a piece of cloth for its beautiful pattern, its color, its design, but not for its length, provided, of course, that it is long enough to serve a useful purpose. It is better to have lived well than merely to have lived long.

But what has this to do with the matter of food? It has everything to do with food. As children we were asked by our teachers, "Do we eat to live, or live to eat?" How could a bright boy answer such a question? If he told the truth he would get a low grade, and so he lied—and knew he lied—every time.

Much too long we have permitted the health cranks to tell us that the things we like will cause our teeth to drop out and our digestion to be ruined. Too long we have eaten the things which we have loathed simply because someone has said that they contained vitamins or whatever it takes to nourish the body. We are not saying that these things are not valuable and even essential, but are merely pointing out that they may be found in a variety of foods

For Acidity and Allied Conditions, we suggest ADAMS SPRINGS MINERAL WATER



● MANY physicians recommend the water in conjunction with the treatment of stomach, liver and kidney trouble.

ADAMS MINERAL SPRINGS is one of these seven known iron and manganese bi-carbonate springs in the world, and the only one in Western America.

It is not a cure-all, but it overcomes acid excesses in the body, and is a very mild but wonderfully effective eliminator. The bowels function without spasm, the kidney output is greatly increased, and there is marked drainage of bile from the gall bladder and liver.

There is also some constitutional upset for a few days, particularly in gall bladder cases. But this is soon over and your patient begins to show improvement and is now in condition to profit by any medication you may prescribe. If the case is an operative one, you have improved your patient and made of him a better risk.

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MANGANESE	1.3 parts per million
IRON	12.5 parts per million
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SODIUM	365.0 parts per million
SILICA	93.0 parts per million
CHLORINE	38.3 parts per million
SULPHATE	16.1 parts per million
NITRATE	0 parts per million
PHOSPHATE	.7 parts per million
CARBONATE	1551.4 parts per million
TOTAL	2591.4 parts per million

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(Since 1870)



and that there are certain emotional as well as purely physical functions which foods must fill. Let us suppose that an individual has the choice of two boarding houses, in the one of which there is an abundance of nutritious

(Continued on Page 44)

**USE ONLY ON ORDER AND UNDER SUPERVISION OF
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EVERY PACKAGE OF S. M. A. HAS BORNE THIS INJUNCTION

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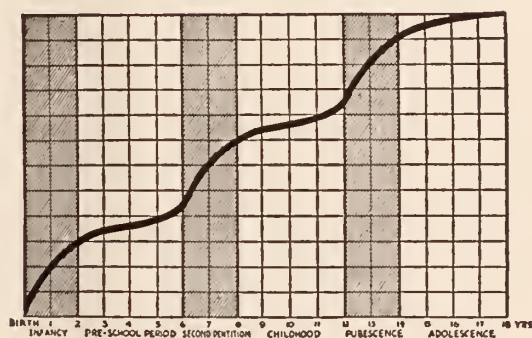
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(Continued from Page 41)

food, but it is tasteless and unattractively served. The companionship is crude and vulgar. In the other boarding house the food is scanty and poorly chosen, but it is clean and tasty. The service is good and the company is pleasant. A person of wisdom and discrimination would certainly choose the latter for the good reason that the mood we eat in is more important than the food we eat.

The individual who insists too much upon the physical and chemical composition of food is forgetting that the best sauce in the world is a mixture of appetite, enjoyment, peace of mind, and zest for living. Life is much more than a regimen. It is necessary to feed the spirit as well as the body. It is as necessary to feed the desire to live as it is necessary to take the means of living. Personally, I should hardly regard the game worth the candle if I had to wear rubbers and woolens, and eat spinach. It is true that we live by plain foods—though being plain they need not be distasteful—but we live *for the dessert*. We may be forced to live by routine, but we live for romance. It is not enough merely to live—one must strive at least to live well.

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VITAMIN REQUIREMENTS OF MAN

II. VITAMIN D

• The quantity of vitamin D required by an individual is influenced by such factors as environment, race, age, mineral content of the diet, and possibly by the source of the vitamin. Deficiency is manifest in children as rickets and decreased calcium retention, and in adults by the less well defined condition known as osteomalacia.

The minimum daily intake which will prevent rickets in infants is probably between 135 and 400 International units of vitamin D as supplied by cod liver oil (1). The optimum prophylactic dose is probably in the neighborhood of 1000 International units (2). It is also interesting to note that the League of Nations Technical Commission has recommended a daily intake of 340 International units of vitamin D for pregnant and lactating women (3).

Irradiated pasteurized milk containing 135 International units per quart and irradiated evaporated milk of the same potency have been found equally effective in preventing rickets in infants. The pediatrician will be interested in the following summary taken from a recent review:

"Such evidence as is available may be interpreted to show that cod liver oil, cod liver oil concentrate milk, and irradiated milk are of equal potency for the human being, unit for unit." (1-b).

Other than the above recommendation for vitamin D intake during pregnancy and lactation (3), little definite information is available upon which to establish minimum vitamin D requirements of the human after infancy (1), yet while sunlight produces the anti-rachitic factor, most common foods are known to be deficient with respect to vitamin D (4). However, certain foods such as eggs, butter, liver and sea foods do supply this vitamin. The importance of sea foods, especially canned salmon, as carriers of vitamin D has been definitely established. A recent report on the vitamin D content of different varieties of canned salmon gave a value of 1.9 International units per gram for the least potent brand and 6 or more units per gram for several other brands (5).

From a consideration of the vitamin D values of salmon oil, the oil content of canned salmon and the quantity of canned salmon consumed annually in this country, it has been concluded that there is more vitamin D in the canned salmon sold in this country than in the cod liver oil used for both human and animal feeding (6).

Although neither the minimal nor optimal requirements of individuals of different ages are definitely known, the values of evaporated milk fortified with vitamin D and of canned sea foods as sources of this important vitamin, are well established.

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(1) a. 1937. J. Am. Med. Assn. 108, 206

b. 1936. Ibid. 106, 2150

(2) 1936. J. Am. Diet. Assn. 11, 503

(3) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.

(4) 1935. J. Am. Diet. Assn. 11, 119

(5) 1935. J. Home Econ. 27, 658

(6) 1931. Ind. Eng. Chem. 23, 1066

This is the twenty-third in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles



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(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, H. Gordon MacLean, 230 Grand Avenue, Oakland.
Secretary, Gertrude Moore, 2404 Broadway, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte County Medical Society
President, John H. White, 315 Wall Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Clara H. Spalding, 331 Eighth Street, Richmond.
Secretary, Thomas J. Dozier, 202 G Street, Antioch.
Meeting, *Second Tuesday, 8 p. m.*

Fresno County Medical Society
President, J. M. Frawley, T. W. Patterson Building, Fresno.
Secretary, O. B. Doyle, Bank of America Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Allan R. Watson, 350 E Street, Eureka.
Secretary, Lawrence A. Wing, Fifth and F Streets, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Floyd A. Burger, Box 193, El Centro.
Secretary, Merritt C. Canfield, 204 Professional Building, El Centro.
Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

Kern County Medical Society
President, H. R. McAllister, Professional Building, Taft.
Secretary, C. S. Compton, 428 C Street, Bakersfield.
Meeting, *Third Thursday, 8:30 p. m.*

Kings County Medical Society
President, P. K. Edmunds, Corcoran.
Secretary, William A. Johnstone, Hanford.
Meeting, *On Call.*

Lassen-Plumas-Modoc County Medical Society
President, C. I. Burnett, Susanville.
Secretary, Fred J. Davis, Jr., Westwood.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, John P. Nuttall, 203 Professional Building, Santa Monica.
Secretary, E. Vincent Askey, 1925 Wilshire Boulevard, Los Angeles.
Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Anne L. Brady, Albert Building, San Rafael.
Secretary, Carl W. Clark, 510 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society
President, Thomas P. Hill, Lakeport.
Secretary, Charles A. Craig, Lakeport.
Meeting, *On Call.*

Merced County Medical Society
President, Max Brannon, Merced.
Secretary, Fred O. Lien, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Garth Parker, 8 East Alisal Street, Salinas.
Secretary, Arthur L. Wessels, Salinas National Bank Building, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, Fred Heegler, Migliavacca Building, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Society
President, John D. Ball, 414 Spurgeon Building, Santa Ana.
Secretary, Glenn Curtis, 323 So. Pomona Street, Brea.
Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital, Orange.*

Placer County Medical Society
President, C. E. Lewis, 59 Lincoln Ave., Auburn.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, H. L. Ratliff, 3616 Main Street, Riverside.
Secretary, Thomas A. Card, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Raymond M. Wallerius, 312 Physicians Building, Sacramento.
Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, L. C. Hull, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, D. C. Mock, 215 Cajon Street, Redlands.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego
President, S. J. McClendon, 2001 Fourth Street, San Diego.
Secretary, W. H. Newman, Medico-Dental Building, San Diego.
Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, T. Henshaw Kelly, 490 Post Street, San Francisco.
Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.
Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, John S. Blinn, 1101 Medico-Dental Building, Stockton.
Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Charles R. Kennedy, Bank of America Building, Paso Robles.
Secretary, E. D. Anderson, 1120 Morro Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Mulholland's Grill, San Luis Obispo.*
(Roster lists continued on advertising page 6)

San Mateo County Medical Society
President, Frank S. Gregory, 736 Main Street, Redwood City.
Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Irving Wills, 1421 State Building, Santa Barbara.
Secretary, William H. Eaton, 822 De la Guerra Terrace, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, R. Stanley Kneeshaw, 404 Medico-Dental Building, San Jose.
Secretary, Leslie B. Magoon, Medico-Dental Building, San Jose.
Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society
President, A. N. Nittler, 36½ Pacific Avenue, Santa Cruz.
Secretary, Samuel B. Randall, Farmers and Merchants Bank Building, Santa Cruz.
Meeting, *Second Tuesday, 7:30 p. m., Hotel Rio del Mar, Aptos.*

Shasta County Medical Society
President, Oscar J. Hansen, 318 Yuba Street, Redding.
Secretary, Leslie J. Seeley, 1432 York Street, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, E. F. Carlson, Fort Jones.
Secretary, J. B. Maguire, Mt. Shasta City.
Meeting, *Second Sunday.*

Solano County Medical Society
President, H. Brownlie Perkins, 445 Georgia Street, Vallejo.
Secretary, John W. Green, Box 539, Vallejo.
Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, C. B. Andrews, Sonoma.
Secretary, C. M. Carlson, 1055 Fourth Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Marion C. Collins, Turlock.
Secretary, Edwin F. Hagedorn, Box 834, Modesto.
Meeting, *Second Friday.*

Tehama County Medical Society
President, Donald E. Thompson, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, J. C. McClure, Lindsay.
Secretary, Karl F. Weiss, Security First National Bank Building, Visalia.
Meeting, *Sunday Evening once a month.*

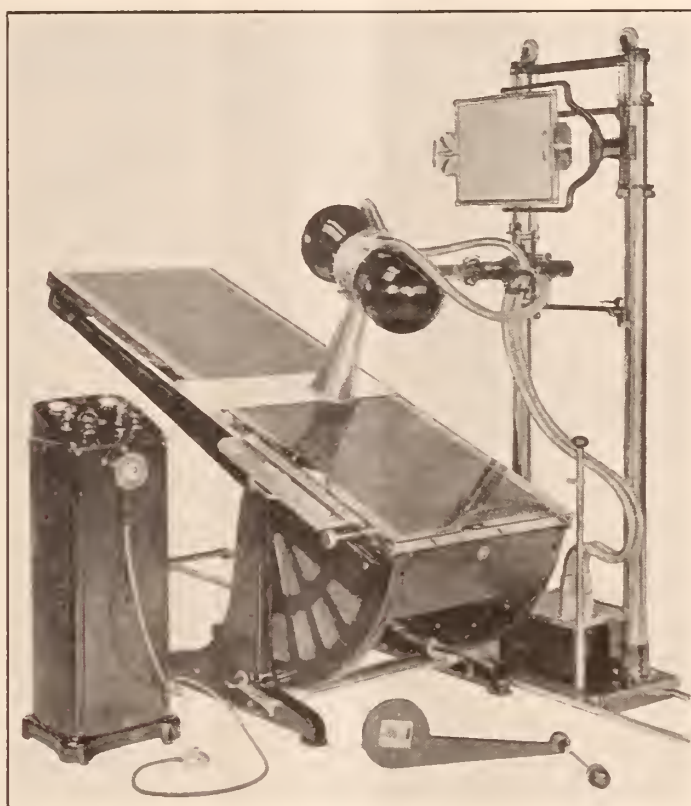
Ventura County Medical Society
President, F. R. Hendricks, 885 East Main Street, Ventura.
Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society
President, Stanley E. Coffey, 239 Fourth Street, Orland.
Secretary, Ray E. Nichols, Woodland.
Meeting, *First Tuesday.*

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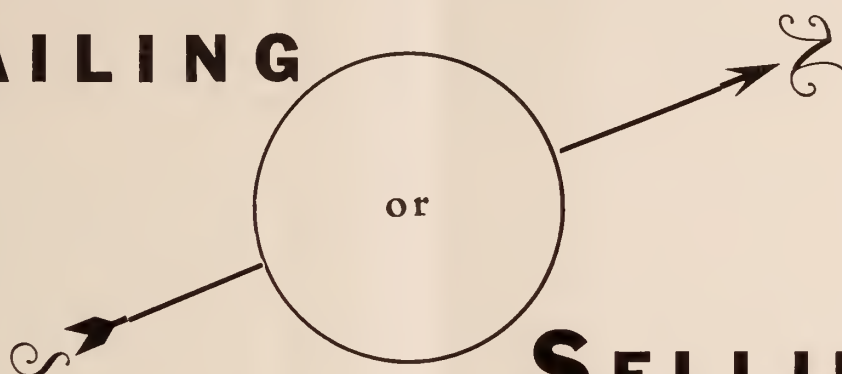
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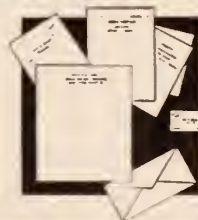
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The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

ALUM ROCK SANATORIUM For Treatment of Tuberculosis San Jose, California	FRENCH HOSPITAL General Hospital Geary at Fifth Avenue, San Francisco	PARK SANITARIUM Mental and Nervous, Alcoholic and Drug Addictions 1500 Page Street, San Francisco, California
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COLFAX SCHOOL FOR THE TUBERCULOUS For the Treatment of Tuberculosis Colfax, California	LIVERMORE SANITARIUM Nervous and General Diseases Livermore, California	ST. MARY'S HOSPITAL General Hospital 2200 Hayes Street, San Francisco
COMPTON SANATORIUM AND LAS CAMPANAS HOSPITAL Neuropsychiatric and General Compton, California	OAKS SANITARIUM For Treatment of Tuberculosis Los Gatos, California	TWIN PINES Convalescent and Neuropsychiatric Belmont, California
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How to Eat.—Though ordinarily we eat three meals a day, this is not the rule of many of us who either work too hard, play too hard, or who are simply careless. The school child or college student may arise too late to partake of an ample breakfast, and may bolt down a mere semblance of a meal or take nothing at all in an effort to arrive in the classroom on time. Lunch is frequently disposed of in the limited time allowed and in not ample enough a quantity or wholesome a quality. Such abuse of the appetite and the digestive organs, combined with the fatigue of the day's activities, renders the third meal rather a task than a pleasure. This daily eating habit is

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Rates for these insertions are \$4 for fifty words or less; additional words 5 cents each.

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Sulfanilamide.—A new chemotherapeutic agent for treatment of streptococcal infections is para-amino-benzene-sulfonamide. It is an effective and specific agent in controlling infections caused by hemolytic streptococci and has been the subject of several medical journal papers which have appeared in this country and abroad. It has been proclaimed as the greatest contribution to chemotherapy since Ehrlich's discovery of arsphenamine.

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BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

Operative Surgery. By J. Sheiton Horsley, M.D., LL.D., F.A.C.S., Attending Surgeon, St. Elizabeth's Hospital, Richmond, Va., and Isaac A. Bigger, M.D., Professor of Surgery, Medical College of Virginia, Surgeon-in-Chief, Medical College of Virginia Hospitals, Richmond, Va. Volumes 1 and 2. Fourth edition. Illustrated by Miss Helen Lorraine. Cloth. Pp. 1,385. Price \$15. St. Louis: The C. V. Mosby Company, 1937.

Endocrinology. Clinical Application and Treatment. By August A. Werner, M.D., F.A.C.P., Assistant Professor of Internal Medicine, St. Louis University School of Medicine; Associate Physician, St. Mary's Group of Hospitals; Physician Endocrine Clinic, St. Louis City Hospital; Staff Member, St. Louis City Hospital, Sanitarium and Infirmary. Cloth. Pp. 672, illustrated with 265 engravings. Price, \$8.50. Philadelphia: Lea & Febiger, 1937.

Lister Centenary Celebration. American College of Surgeons, Detroit, Michigan, October, 1927. Descriptive Catalogue Lister Collection. Cloth. Pp. 140, illustrated. London: The Wellcome Historical Medical Museum.

International Clinics. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles. By leading members of the medical profession throughout the world. Edited by Louis Hamman, M.D., Visiting Physician, Johns Hopkins Hospital, Baltimore, Md. Volume I, Forty-seventh Series, 1937. Cloth. Pp. 310. Philadelphia: J. B. Lippincott Company, 1937.

Cancer and Diet. With Facts and Observations on Related Subjects. By Frederick L. Hoffman, LL.D., The Biochemical Research Foundation of the Franklin Institute, Philadelphia. Cloth. Pp. 767. Price, \$5. Baltimore: The Williams & Wilkins Company, 1937.

Preoperative and Postoperative Treatment. By Robert L. Mason, A.B., M.D., F.A.C.S., Assistant in Surgery at the Massachusetts General Hospital. Cloth. Pp. 495, with 123 illustrations. Price, \$6 net. Philadelphia: W. B. Saunders Company, 1937.

The Diseases of Infants and Children. By J. P. Crozer Griffith, M.D., Ph.D., Emeritus Professor of Pediatrics in the University of Pennsylvania; Consulting Physician to the Children's Hospital, Philadelphia; Consulting Physician to St. Christopher's Hospital for Children; Consulting Pediatricist to the Woman's, the Jewish, and the Misericordia Hospitals, etc.; Corresponding Member of the Société de Pédiatrie de Paris; and A. Graeme Mitchell, M.D., B.K. Rachford Professor of Pediatrics, College of Medicine, University of Cincinnati; Medical Director and Chief of Staff of the Children's Hospital of Cincinnati;

(Continued on Next Page)

NEW MEDICAL BOOKS

Boyd: Introduction to Medical Sciences.....	\$3.50
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Mathews: Vitamins, Minerals and Hormones..	1.50
Saphir: Autopsy Diagnosis and Technique....	5.00
Werner: Endocrinology.....	8.50

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BOOKS RECEIVED

(Continued from Preceding Page)

Director of the Children's Hospital Research Foundation; Director of Pediatric and Contagious Services in the Cincinnati General Hospital. Second Edition, Revised and Reset. Cloth. Pp. 1,153, with 293 illustrations. Price, \$10 net. Philadelphia: W. B. Saunders Company, 1937.

BOOK REVIEWS

Endocrinology. August A. Werner, M. D., St. Louis University. Cloth. Pp., 672; 265 engravings. Price \$8.50. Lea & Febiger, Philadelphia.

The author has made a worth while endeavor to give to the profession the accepted knowledge that we possess on the normal and abnormal physiology of the ductless glands, the physical disorders caused by disordered function and interpretation of endocrine syndromes.

Essential fundamentals are discussed. Functions are outlined. Extended references are cited. Illustrative clinical cases are well selected.

When it comes to treatment the author commendably stresses the careful determination of the etiology of the syndrome as being of primal importance before any thought can be given to treatment measures. Again he points out the need for potent preparations and warns against the use of promiscuous products.

The text as a whole will be of great value in aiding practitioners to obtain sound information that will be valuable to him in his private practice.

Operative Surgery. J. Shelton Horsley, M. D., Richmond, Virginia. Two volumes. Fourth edition. Price, \$15. C. V. Mosby Co., St. Louis.

The first three editions of this standard surgical text have been reviewed and warmly commended. The fourth edition is now available. It is under the sponsorship of the original author, who has called to his assistance Isaac A. Bigger, M. D., and obtained contributions from Doctors C. C. Coleman, Neurological Surgeon; J. S. Horsley,

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Doctor Horsley well states that no one man can remain authoritatively informed or experienced in all of the special fields of surgery. He has done well to enlist the cooperative assistance of competent co-editors.

As to the text and its well-selected illustrations, there can be no hesitancy in appraising it as an up-to-date, authoritative surgical text. The obsolete has been discarded. New, accredited principles and technique have been included and enable the reader to obtain advice that is up-to-date.

This text warrants a more extended review. However, that is impossible and would consist largely in commenting upon the special features of each chapter. Suffice it to state that these two volumes exhibit surgical standards and progress of this year.

Autopsy Diagnosis and Technique. Otto Saphir, M. D., Pathologist, Michael Reese Hospital, Chicago. Pp. 342. Price \$5. Paul B. Hoeber, Inc., New York.

This is a manual for medical students, practitioners, pathologists and coroners' physicians. It has a foreword



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by Dr. Ludvig Hektoen. Sixty-five well selected illustrations enrich the text.

The manual is a modification of the Rokitsansky's method and is an excellent guide for performing autopsies that can be intelligently summarized. Saphir has made available a guide that will be of helpful value to every autopsy surgeon.

The Diseases of Infants and Children. By J. P. Crozar Griffith, M. D., Ph. D., Emeritus Professor of Pediatrics in the University of Pennsylvania; Consulting Physician to the Children's Hospital, Philadelphia; Consulting Physician to St. Christopher's Hospital for Children; Consulting Pediatricist to the Woman's, the Jewish, and the Misericordia Hospitals, etc.; Corresponding Member of the Société de Pédiatrie de Paris; and A. Graeme Mitchell, M. D., B. K. Rachford Professor of Pediatrics, College of Medicine, University of Cincinnati; Medical Director and Chief of Staff of the Children's Hospital of Cincinnati; Director of the Children's Hospital Research Foundation; Director of Pediatric and Contagious Services in the Cincinnati General Hospital. Second edition, revised and reset. Pp. 1,153, with 293 illustrations. Philadelphia and London: W. B. Saunders Company, 1937. Cloth, \$10 net.

Excellent, clear in meaning, dependable in specific details, voluminous references, and extremely practical. Such is the appraisal of this text. Specialists will do well to consult it and general practitioners will find it to be tremendously helpful in their care of infants and children. We like the chapters on pneumonias and on diseases of the heart because of their modern, up-to-date, thorough and sound presentation and discussion. The same opinion is formed on the diseases of the brain and meninges, which chapters merit repeated reading.

Preventive measures are emphasized. Feeding is on a simplified basis. Tuberculosis is fully discussed. Infectious diseases are carefully covered. Acid-base balance and diabetes, in fact every subject is well done. In consequence there is but one conclusion: this text will serve most satisfactorily as a modern, dependable treatise of diseases of infants and children.

Cancer and Diet. Frederick L. Hoffmann, LL. D., Research Foundation. Pp. 767. Williams & Wilkins Co., Baltimore. Price, \$5.

A presentation of the author's observations and opinions on this subject gained through many years of study. Interesting to read even though everyone cannot accept all the conclusions recorded. There are many excellent dietetic suggestions regardless of any relations to cancer.

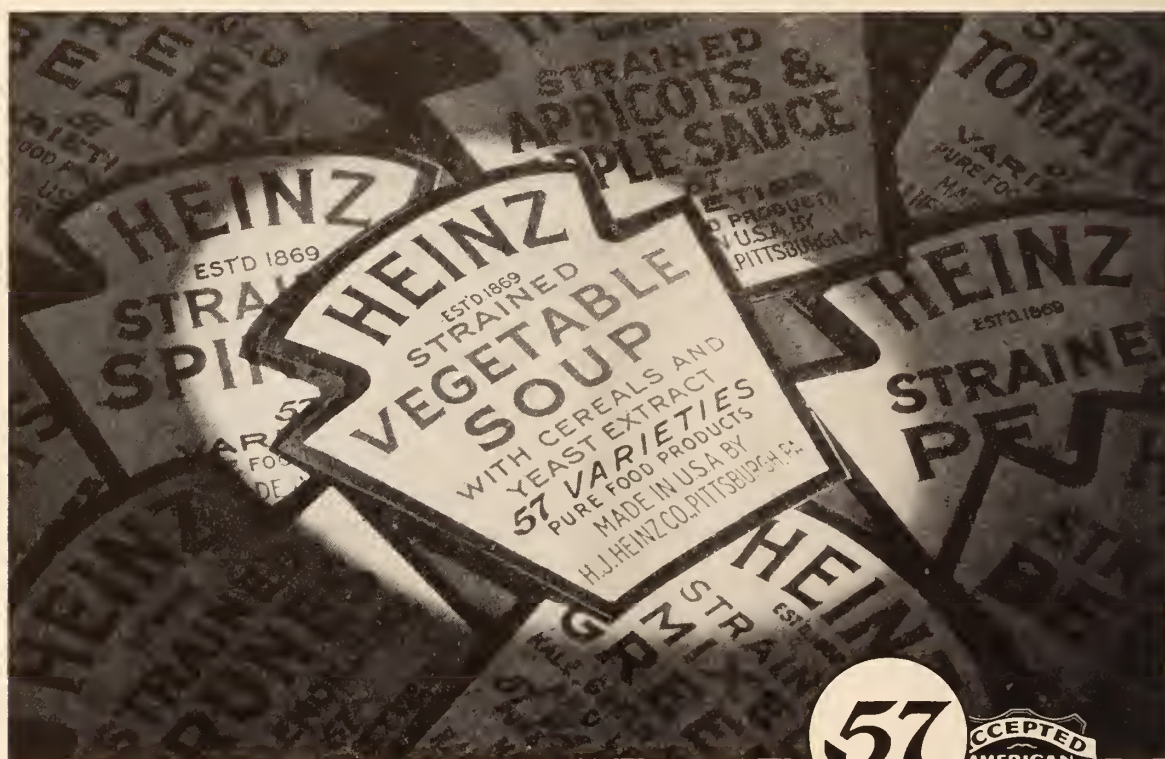
Preoperative and Postoperative Treatment. By Robert L. Mason, A. B., M. D., F. A. C. S., Assistant in Surgery at the Massachusetts General Hospital. Pp. 495, with 123 illustrations. Philadelphia and London: W. B. Saunders Company, 1937. Cloth, \$6 net.

With the assistance of twelve contributors, Mason has presented a rather complete summary of recognized forms of pre and postoperative treatment. Standards and methods have a limited value, for after all it is the particular condition and the individual patient that requires careful, individualistic pre and postoperative care. Standards in Boston may not be applicable in St. Paul. It is the principles that are so important upon which methods are developed. These the surgeon develops from his studies and experiences.

As a single illustration, Mason expresses preference for Dakin's solution for irrigation in empyema. Because of this reviewer's experience and the untoward after results of the use of Dakin's in the pneumonia epidemic during the war and subsequently, our strong opposition is based to the use of this solution. Hence there are bound to be differences of opinion with resulting different methods.

On the whole, this is a good review of methods to be observed in rendering pre and postoperative care. It should enable the young resident and assistant to establish a plan of care based upon his enlarging experience.

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TWENTY-FIVE YEARS AGO

(Continued from
Text Page 288)

fixation test to syphilitic serum, and Ehrlich's production of salvarsan, are now medical history. It is history of the sort that does not lighten the physician's labor, but does make it more interesting. All these factors are the result of laboratory work, and lead more and more to depending upon laboratory methods in the diagnosis and prognosis of syphilis. Technically speaking, a record may be considered incomplete without finding the *Spirocheta pallida* in the early lesions or without a positive Wassermann finding in either early or late lesions. But practically speaking, the majority of cases that the dermatologist sees do not require either of these for a positive diagnosis. . . .

Dr. Elias S. Cooper, Surgeon.—In a recent "Bulletin of the Society of Medical History of Chicago," it is recorded among other incidents in the early history of medicine in Illinois, that "Dr. Elias S. Cooper was the first man to use chloroform as an anesthetic west of Pennsylvania." . . .

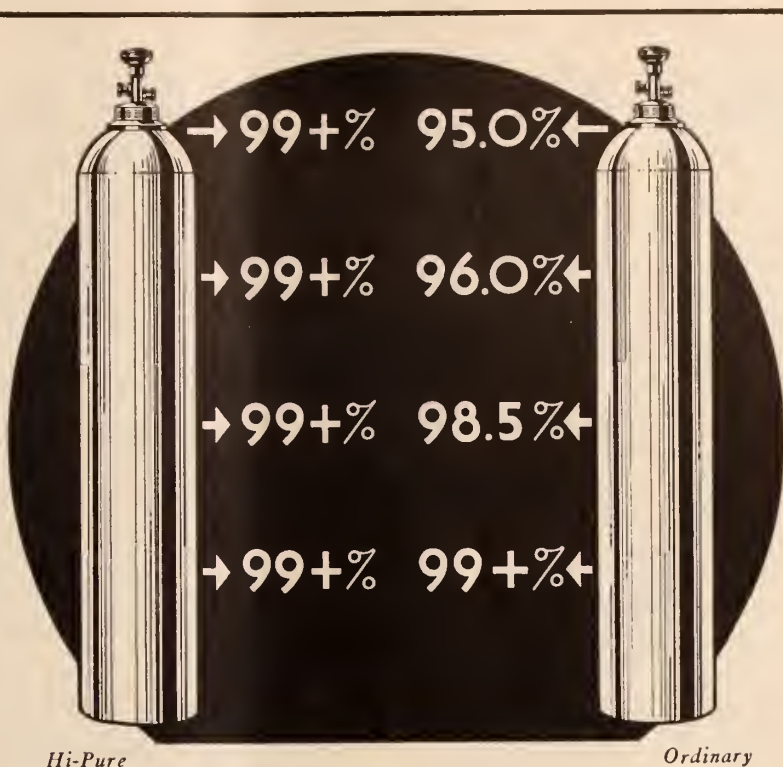
"He studied anatomy and surgery in Paris. He built the first hospital in Peoria, Illinois, and later he removed to San Francisco, where he became the most renowned surgeon on the Pacific Slope and in whose honor Cooper Medical College was named." . . .

A few years later the nephew of Doctor Cooper, Dr. Levi Cooper Lane, came into the new college, also from Illinois, well equipped with scholastic attainments and sharing alike with Doctor Brainard and Doctor Cooper their love for surgery and exalted beneficence, a worthy follower to supplement and to perpetuate the great work of his uncle, Doctor Cooper. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 288)

Following receipt of many complaints, Acting Special Agent John R. Ronan arrested Theodore T. Jacobsen in Los Angeles on a charge of violation of the Medical Practice Act. This individual maintained an office at 607 South Hill Street, on the door of which was the following sign: "725—T. T. Jacobsen, M. D., LL. D., Medico-Legal Jurisprudence Consultant—California laws interpreted for the layman." He was released on \$500 bond, pending trial on March 17. At the time of his arrest he



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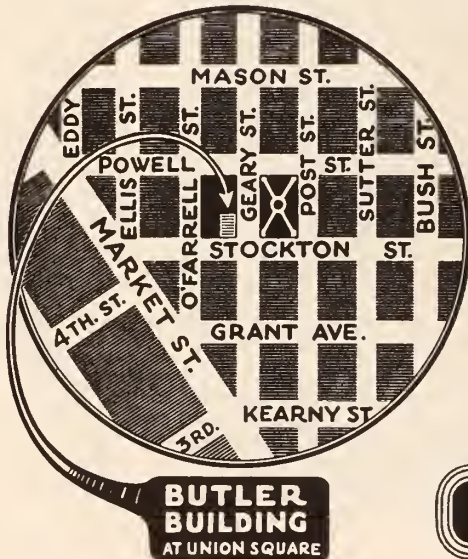
SHAW SUPPLY Co., INC.
Seattle, Portland and Tacoma

is said to have stated he was licensed in Ohio, but retired in 1915. A letter from H. M. Platter, Secretary of the Ohio Board, dated Columbus, March 4, 1937, states their records show Theodore Tobias Jacobsen was graduated from the Cleveland College of Physicians and Surgeons, May 4, 1898, and was licensed in Ohio the same year. "Dr. Theodore Tobias Jacobson's certificate was revoked by this department on October 3, 1916, upon the grounds of grossly unprofessional conduct. . . . In 1919 he was arrested by an inspector from this department and charged with illegal practice of medicine in Covington, Miami County, and again in 1919 he was prosecuted for the illegal practice of medicine, that is practice after his certificate had been revoked, in the Municipal Court of Cleveland before Judge McMahon, and was found guilty on January 13, 1920. His activities in the case mentioned from Miami County, as I recall it, were in connection with a fake radium outfit; however, this case was never

(Continued on Next Page)

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AGENTS

San Francisco

BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

brought to trial. I suggest also you make inquiry of his activities in North and South Dakota. . . ."

Investigation reports relate that Samuel Roos Lustberg, M. D., on February 17 was charged by an inspector of the Optometry Board with violation of Section 1 of the Optometry Act, pleaded not guilty, and his trial set for March 15. (Previous entry May and August, 1935.)

A news item printed in the Havana (Cuba) *Post*, February 10, 1937, reports that the Havana Secret Police were holding Dr. George Ozawa, also known as Yukihi George Ozawa, "while they investigated the possibility that he has been engaged in smuggling narcotics and espionage here. . . . Ozawa was dressed in the uniform of a Japanes naval lieutenant-commander and told police he was a naval attaché of the legation of his country in Havana, but, according to police, this was denied by the Nipponese officials. . . ." The records of the Board of Medical Examiners show that this individual has been the subject of correspondence over a period of several years because of his false claim to be a graduate of the University of California Medical School. In 1930 Ozawa signed an acceptance blank for internship in the Cene-maugh Valley Memorial Hospital, Johnstown, Pennsylvania, and in 1934 applied for a position on the staff of Mount Alto (Pennsylvania) State Hospital. In each instance he falsely claimed to be a graduate of the University of California Medical School. In May, 1930, he was an intern at the Hospital and Home for Crippled Children, Newark, New Jersey.

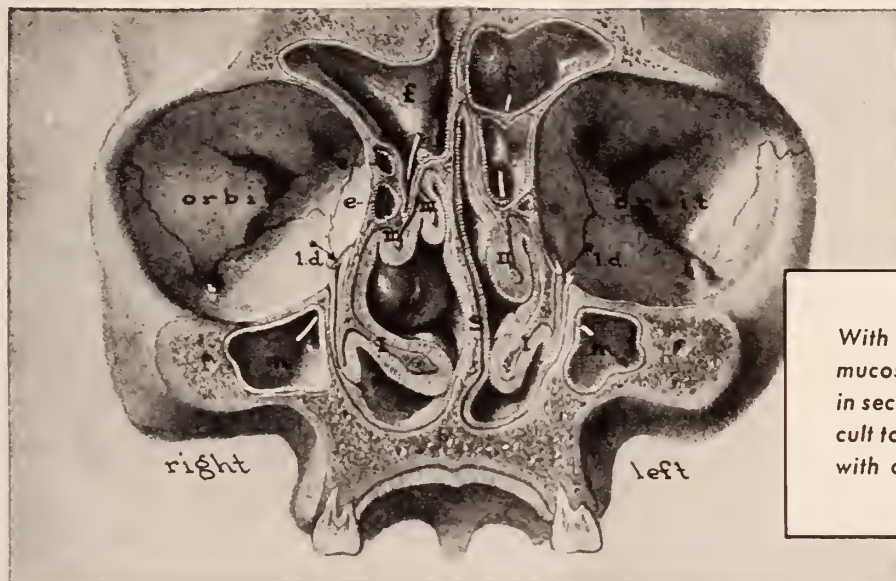
Attorney-General Webb on February 27, 1937, rendered Opinion No. NS-172 to the effect that Section 1 of the

State Narcotic Act made it unlawful "for any person except a physician and surgeon, dentist, or veterinary surgeon, to sell, furnish, or give away any narcotic drugs. This would prohibit the dispensing of same by a chiroprapist. You are, therefore, advised that chiropradists may not prescribe, dispense, or administer any narcotic drugs."

A report indicates that James Henry Beggs, M. D., and Alfred Henry Valentine St. John, M. D., both convicted in connection with the Pacific Coast abortion ring, were on February 15, 1937, released by Superior Judge Aggeler from the Los Angeles County Jail on \$3,000 bond.

Romano N. Trotsky, featured in the *Journal of the American Medical Association*, December 22, 1934, and mentioned as a "deportable alien, with many aliases and a criminal record, who has persistently violated the Medical Practice Act of various states, has served time in the Minnesota State Prison for abortion, went to the federal penitentiary at Leavenworth for a year and a day for violation of the Dyer Act and has been charged with forgery and other forms of swindling," has recently been investigated by the Board of Medical Examiners, both in San Francisco and Los Angeles. He is said to use the aliases Bob Anthony, Ray Armstrong, Bok Lukan, and Romano Trotsky. Our San Francisco investigation department recently acquired a document in the Russian language, said to have been displayed on all occasions by Trotsky, who claimed that it was a license to practice medicine in Russia. According to the English translation of said document, it is neither a medical diploma nor a license, but merely, as noted thereon, "A notation from the Medical Act (Russia) Chapter 225, published 1905." No authentic information is obtainable to show that Trotsky has had any medical training; however, he is reported as having visited various hospitals in San Francisco, claiming to be a nose and throat specialist.

IN SINUSITIS



With congestion of the nasal mucosa as here represented in section, it is obviously difficult to reach all affected areas with a liquid vasoconstrictor.

In sinusitis 'Benzedrine Inhaler' is especially useful. The structure of the rhinological tract is so complicated that, when congestion is present, the whole of the affected area cannot easily be reached by a liquid vasoconstrictor.

The vapor from 'Benzedrine Inhaler,' diffusing through the nasal cavity, reaches and relieves congestion. Thus it not only affords improved respiratory ventilation, but also helps to re-establish drainage of the accessory sinuses—an important factor in preventing acute attacks from becoming chronic.

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Each tube is packed with benzyl methyl carbinamine, .325 gm.; oil of lavender, .097 gm.; menthol, .032 gm.

'Benzedrine' is the trade mark for S. K. F.'s nasal inhaler and for their brand of the substance whose descriptive name is benzyl methyl carbinamine.



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Diseases Reportable in California

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Anthrax	Pellagra
Beriberi	Pneumonia (lobar)
Botulism	Relapsing fever
Coccidioidal granuloma	Rocky Mountain spotted fever
Dengue ¹	Septic sore throat
Fluke infection	Tetanus
Food poisoning	Trichinosis
Glanders ³	Tularemia
Hookworm	Undulant fever
Jaundice (infectious)	
Malaria ¹	

ISOLATION OF PATIENT

Chickenpox ²	Ophthalmia neonatorum
Dysentery (amebic)	Psittacosis
Dysentery (bacillary)	Rabies (animal) ²
Erysipelas	Rabies (human)
German measles ²	Syphilis
Gonococcus infection	Trachoma
Influenza	Tuberculosis
Measles ²	Whooping cough ²
Mumps ²	

QUARANTINABLE

Cholera ³	Scarlet fever
Diphtheria	Smallpox
Encephalitis (epidemic)	Typhoid and paratyphoid fever
Leprosy	Typhus fever
Meningitis (epidemic)	Yellow fever ³
Plague ³	
Acute anterior poliomyelitis	

¹ Patients should be kept in mosquito-free room.

² Non-immune contacts isolated also.

³ Cases to be reported to State Department of Public Health by telephone or telegraph, and special instructions will be issued.

Trichinosis Leaflet Issued in Handy Size.—To supplement its recent poster advising the thorough cooking of pork, the Bureau of Animal Industry, has prepared a handy 4 by 8-inch four-page leaflet, convenient for enclosure in letters and packages. It supplies additional information regarding trichinosis, a disease which sometimes follows the eating of raw or imperfectly cooked pork.

The leaflet may be obtained on application to the Bureau at Washington, D. C. It is entitled "Cook Pork and Its Products Thoroughly," and is numbered A. I. 39.

The leaflet points out that hygienic precautions are necessary in preparing many foods. "Most fruits and vegetables," the text states, "are thoroughly washed or peeled. Milk is commonly pasteurized to destroy harmful bacteria that may be present, and water supplies are treated, if necessary, for purification and safety to health."

The text shows also that thorough cooking of pork is advisable not only for hygienic reasons but also for the development of rich flavor. Besides dealing with reasons for thorough cooking, the leaflet states the main sources of trichinosis, emphasizes that large cuts of pork require more cooking than smaller pieces, describes the processing of certain kinds of pork products prepared under federal meat inspection, and includes a small facsimile of the cook-pork poster.

Courts Fine and Reprimand Patent Medicine Manufacturers.—Federal courts in Los Angeles, Baltimore, Pittsburgh, and other large cities sentenced and reprimanded shippers of patent medicines found guilty of violating the Food and Drugs Act, says the Federal Food and Drug Administration in summarizing its recent activities.

A significant case, in the view of the enforcing officials, was that against Mrs. Adah Alberty, proprietress of the Alberty Food Laboratories, and also operating as "U. S. Okey," Los Angeles California. A fine of \$1,000 and costs of \$1,478.30 were imposed by the court. Mrs. Alberty had

(Continued on Page 23)

One of a series of advertisements prepared and published by PARKE, DAVIS & CO. in behalf of the medical profession. This "See Your Doctor" campaign is running in the *Saturday Evening Post* and other leading magazines.

"I never want to go to another party!"



"BUT, dear, tell Mother—what *is* the matter?"

"They wouldn't let me play with them. They let me be by myself all the time. They—they *laughed* at me."

What should Mother do? Denounce the other children as ill-raised little barbarians? Prevent further contact with the youngsters who should be the child's playmates, and the neighborhood that should be her happy little world?

Those would be natural and understandable reactions for any mother. But unfortunately, they would tend only to make matters worse.

When a child is "different" or "difficult," the most sensible thing to do is to get the help of your doctor. And the reason is that the underlying cause, while occasionally psychological, is usually *physical*.

For instance, a child can be slow and awkward at childhood games, because anemia is robbing her of energy. A child can appear backward because a glandular disorder is causing sluggishness, because faulty hearing prevents her from catching questions, or because faulty eyesight prevents her from reading correctly. A child can be sulky or ill-tempered, not because it is her nature to be so, but because some physical derangement is *making* her act that way.

The tragedies these disorders heap upon little heads are very real tragedies. But even more serious is their possible influence on the child's future. The "laughed-at" child so often becomes the crushed and morose adolescent. And the morose adolescent frequently becomes an embittered man or woman in an unfriendly world.

If your child's present and future happiness is being threatened, see your doctor. You will find him a helpful and understanding friend.

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"Doctor, it means a lot to all us little fellers to have you see the *Mennen exhibit* at your convention. I'm counting on you, doctor—'cause I want you to hear, at first hand, the latest news about the remarkable job Mennen Antiseptic Oil is doing to protect us babies."

The success story of Mennen Antiseptic Oil is an amazing one. Already in five short years, doctors in more than 2,400 hospitals have made Mennen Antiseptic Oil a part of the standard routine of delivery and post-delivery practice.

Mennen Antiseptic Oil is invaluable for removing the vernix antiseptically and for providing dependable non-irritant antiseptics in the baby's initial cleansing and in his daily oil baths. It is recommended for daily use until the baby out-grows the diaper age.

In antiseptic potency, Mennen Oil is superior to the commonly-used ammoniated mercury ointments, yet it is absolutely non-toxic and non-irritant. It leaves no greasy residue, is pleasant to handle and can be used day-in-and-day-out without danger of dermatitis.

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VICHY CÉLESTINS



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(Continued from Page 20)

shipped four medicines—"Calcatine," "Liver Cell Salts," "Lebara Pellets," and "Anti-Diabetic Vegetable Compound Capsules"—found by government analysts to contain no ingredients warranting the representation that the products were adequate treatments for malaria, diseases of the liver, constitutional defects, tubercular tendencies, acidosis, diabetes, and other conditions set forth in the labeling and circulars.

Medical experts testified at the trial, which lasted nearly a week, that neither the homeopathic nor the allopathic school of medicine recognized Mrs. Alberty's preparations as treatments for the diseases named. It was shown, further, that the company had ignored the Administration's advice not to place the products on the market, as their interstate shipment would constitute a violation of the law if the proprietress insisted on retaining the false representations.

The composition of the different preparations was as follows: "Calcatine," "Liver Cell Salts," and "Lebara Pellets"—one-grain tablets, consisting of sugar of milk with one-tenth of one per cent calcium phosphate, iron, magnesium, sodium, and potassium salts, and chlorids; "Anti-Diabetic Vegetable Compound Capsules"—capsules containing slightly more than one-half gram of mixed dried asparagus, beet leaves, cauliflower, celery, lettuce, spinach, tomatoes, and watercress.

Richard Diener, operating as the Curarina Agency, Oxnard, California, was called into the same court two weeks later, the report continues. His product, also alleged to violate the federal law, was "Curarina," a water and alcohol solution of plant extracts, containing no curare alkaloid, offered for the treatment of all diseases of the blood, heart trouble, sciatica, sinus trouble, rheumatism, snake and insect bites, mumps, malaria, diabetes, pneumonia, smallpox, tonsillitis, influenza, grippe, lockjaw, cholera, hemorrhages, appendicitis, distemper in animals, ptomaine poisoning, arthritis, not to mention some nameless tropical disturbances described with all possible gory details in the circulars. Diener, who pleaded not guilty

when the case was called, reversed his stand when about half of the government's expert testimony was in, and pleaded guilty. A fine of \$520 was imposed.

In federal court at Baltimore, Judge Chestnut reprimanded a shipper of another patent medicine fraud. The case was that against Thomas F. Maher, trading as Gowan Chemical Company, Baltimore, Maryland, shippers of "Gowan's Preparation," falsely represented as a treatment for pleurisy, spasmodic croup, coughs, congestion, and pneumonia. The article was a salve, consisting of lard, turpentine, carbolic acid, and volatile oils. In his remarks to the defendant on the witness stand, the Court said, "The point of the case is this, that you have been selling a patent medicine with representations to the public that it is an effective remedy for a valuable aid in cases of disease, when it could not have any possible real value in such disease, and anybody of real intelligence, and particularly in your line of business, must have known that. Something more is required of a man who undertakes to make a profit in selling drugs to the public than merely a willingness to change when he is caught or found out by the Department of Agriculture. It is the affirmative duty of the citizen to comply with the law. Of course, there are a great many provisions of the law that the average citizen does not know about; but a man who is in a gainful pursuit with regard to the selling of drugs certainly ought to know whether the thing that he is selling to the public is sold under fair representations or false representations." In view of the fact that the company has revised its labeling, the Court imposed a nominal fine of \$25.

Other medicine cases terminated with penalties imposed by the courts were:

Vasco Products, Inc., Brentwood, Maryland, "Colac Pile Pills," containing iron and magnesium oxides, calcium carbonate, plant drugs and a tar-like material, falsely offered for the cure of piles, fine \$200; Sweet Manufacturing Company, Pittsburgh, Pennsylvania, "Sweet's Cough Balsam," consisting of extracts of plant drugs, in-

(Continued on Next Page)

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(Continued from Preceding Page)

cluding wild cherry, pine tar, chloroform, and alcohol, in syrup, for coughs and pulmonary disorders, and "Sweet's Rheumatic Remedy," tablets containing acetphenetidin, potassium iodid, sodium salicylate, caffeine, and plant extracts, for rheumatism, fine \$100 and costs; Paul B. Elder Company, Bryan, Ohio, phenobarbital tablets, containing less than the claimed amount of phenobarbital, and "Pro-targol Suppositories" not of the claimed composition, and represented as a treatment for venereal disease, fine \$50 and costs; Fallis, Inc. (William S. Spero and Herman Arkus), New York, N. Y., witch-hazel extract, offered for the treatment of rheumatism and piles, and "Alcohol-Rub," consisting of a mixture of isopropyl alcohol and water, fine of \$200 against the corporation, and suspended sentences against the individuals; Lederle Laboratories, Inc., New York, N. Y., Hoosier Pharmacal Company, Indianapolis, Indiana, Intra Products Company, Denver, Colorado, Reliance Dental Manufacturing Company, Chicago, Illinois, and Dios Chemical Company, St. Louis, Missouri, substandard pharmaceuticals and other drug products misbranded as to composition, fines of \$100, \$25, \$50, \$25, and \$500 and costs, respectively.

Drug products seized included 475 packages of gauze bandage and 140 boxes of gauze pads, represented as sterile when in fact unsterile; and the following patent medicines:

"Astyptodyne Cough Syrup," a sugar syrup with $1\frac{1}{4}$ per cent pine oil, offered for the treatment of coughs, bronchitis, croup, sore throat, whooping cough and other diseases of the throat and chest; "Astyptodyne Ointment," petrolatum with 12 per cent pine oil, for piles.

"Bol Lecznik Liniment," containing alcohol 61 per cent (the label stated 41 per cent), chloroform 4.6 minims per fluidounce (72 minims declared), ether ammonia, capsicum, water, peppermint, and mustard oil, for muscular rheumatism, stiff neck, pains in the sides, chest and back, nasal catarrh, grippe, neuralgia, sore throat, and coughs; "Cereal Lactic" powder and capsules, represented as a source of bacillus acidophilus when in fact deficient in

living organisms of that type, and contaminated with extraneous organisms: "Gay" tablets, each containing two grains acetylsalicylic acid, 1.7 grains acetphenetidin, and one-quarter grain caffeine, with plant material, bearing on the label no declaration of the presence of an acetanilid derivative, and falsely represented as non-habit-forming and as containing no harmful drugs, for the relief of pain.

"Henry's Deep Rock Oil," petroleum with cade, turpentine and cajeput oils and wintergreen, for pains in the chest, side, back and kidneys, bladder troubles, cough, sore throat, weak lungs, asthma, swellings, sore feet, and rheumatism; "Masc Zywokostowa Ucco Salve," made of menthol, camphor, eucalyptol, wintergreen oil and salicylic acid in a petrolatum base, for sore throat, tonsillitis, stiff neck, neuralgia, rheumatism, congestion, sore muscles, bronchitis, croup, lumbago, pains and aches of the back and joints, colds in the chest, and to prevent pneumonia; "Musterdone," another petrolatum-base salve, containing camphor, menthol, salicylic acid, wintergreen, and mustard oil, for sore throat, tonsillitis, stiff neck, neuralgia, rheumatism, congestion, sore muscles, bronchitis, croup, lumbago, pains and aches of the back and joints, colds in the chest, and to prevent pneumonia.

"N. A. No. 7," a water solution of iron and manganese sulfates, small amounts of calcium, manganese, aluminum, and phosphates, falsely represented as antiseptic, for rheumatism, indigestion, dysentery, diarrhea, sore throat, fresh cuts and itch, and for kidneys and tonsils; and "N. A. No. 7½," water solution of iron and magnesium sulfates, small amounts of quinin, aluminum, phosphate, and chlorid, for stomach, liver and kidneys, stomach trouble, sour stomach, sick headache, chills, fever, ague, tired and run-down feeling, heartburn, sallow complexion, nervousness, malaria, loss of appetite, and for ills arising from impurities of the blood.

"Rx 333 for Females," water, alcohol 34 per cent, and small amounts of phosphates, magnesium compounds, protein and perfume. "Rx 444 for Males," same composition except for 40 per cent alcohol (the label declared 25 per

(Continued on Page 26)

A Poor Scholar . . . because of a Poor Breakfast

MANY a child is scolded for dullness when he should be treated for undernourishment. In hundreds of homes a "continental" breakfast of a roll and coffee is the rule. If, day after day, a child breaks the night's fast of twelve hours on this scant fare, small wonder that he is listless, nervous, or stupid at school.

Pablum offers a happy solution to the problem of the school-child's breakfast. Mothers who learn about Pablum from their physicians are delighted to serve it for it needs no cooking and can be prepared in a minute at the table—more quickly than many less nourishing foods. Pablum not only ends the bane of long cooking of cereals but in addition furnishes a variety of minerals (calcium, phosphorus, iron, and copper) and vitamins (B and G) not found so abundantly in any other cereal.



PABLUM is rich in calcium and iron, minerals likely to be deficient in the school-child's diet yet needed in more than average amounts during childhood. Pablum is 6 times richer than fluid milk in calcium and contains 10 times more iron than does spinach. It also furnishes generous amounts of vitamins B and G, essential for normal appetite. Unlike other cereals, Pablum is base-forming, important because the growing child needs to store alkali. The nutritional value of Pablum is attested in studies by Crimin *et al*

"TOMMY, that's the third time this week you haven't learned your lesson. Why don't you listen to me when I tell you how to work the problems?"



who found that tuberculous children receiving supplements of Pablum showed greater weight-gain, greater increase in hemoglobin, and higher serum-calcium values than a control group fed farina. Reprint sent on request of physicians. Mead Johnson & Company, Evansville, Ind., U.S.A. Pablum (Mead's Cereal thoroughly cooked) is a palatable cereal enriched with vitamin- and mineral-containing foods, consisting of wheatmeal, oatmeal, cornmeal, wheat embryo, alfalfa leaf, beef bone, brewers yeast, iron salt, and sodium chloride.

Please enclose professional card when requesting samples of Mead Johnson products to cooperate in preventing their reaching unauthorized persons



TO THE DOCTOR'S WIFE



It is our conviction that cosmetics should be selected to suit the individual's requirements. We cater exclusively to you, the individual. Our representatives are trained to help you select suitable beauty preparations and to show you how to apply them.

It is only sensible to realize that a truly beautiful skin is first of all a healthy skin and secondly a well-cared-for skin.

Cosmetics serve to enhance your appearance, to present you at your best. In this regard it is well to bear in mind that a natural appearance is by far the most charming.

Carefully selected, and artistically applied, make-up preparations lose their identity as cosmetics and become an indistinguishable part of your personality.

We want it clearly understood that we in no way undertake to treat skin disorders. If you are thus afflicted we had rather that you not use our preparations without the consent of a skin specialist. Our formulary is available to the medical profession.

A card addressed to us will be referred to the manager of the territory in which you reside. It is our pleasure to be at your service.—LUZIER'S, Inc.

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Psychiatry

(Continued from Page 24)

cent alcohol in both cases), the products to be rubbed on the skin of the forearm, for ovarian disorders, amenorrhea, dysmenorrhea, sterility, apathy, associated neuroses and psychoses, circulatory unbalance, climacteric disorders, nervous disturbances at menopause, arthritis, glandular unbalance, rheumatism, obesity, prostatitis, backaches, nervous restlessness, sciatica, disturbed digestion, insomnia, and loss of weight. "Scheidemann Remedy—Tea," consisting of ground twigs, wood, needles, and juniper berries, for diabetes and kidney disorders.

"Spratt's Roupine Liquid Roup Treatment," 99½ per cent water and the remainder aloe and mineral matter, for roup in poultry, ducks, geese, turkeys, pheasants, and game birds; "Spratt's Treatment for Bacillary White Diarrhea," a solution of sodium hypochlorite in water, for white diarrhea and coccidiosis in chicks.

"Universal Kidney, Liver, and Stomach Tea," being dried herbs and seeds, including anise, senna and lavender, for dyspepsia, nervous debility, stomach, liver, kidney and bladder ailments, female weaknesses, painful and suppressed menstruation, nervousness, headache, insomnia, and indigestion; "Universal Brand Stomach Drops," made of alcohol, water, glycerin, capsicum, a laxative plant drug, and peppermint oil, for stomach and bowel derangements, cramps, stomachache, dysentery, diarrhea, colicky pains, indigestion, cholera morbus, backache, sore throat, asthma, and pain in the chest; "Universal White Pine Cough Balsam," a mixture of pine tar, salicylic acid, resinous material, alcohol and water, for coughs, hoarseness, sore throat, bronchitis and other affections of the throat and lungs.

"Vagi-Anti-Septikones," hydroxyquinolin in cocoa butter, for women's ailments; "Venida Mentho-Kerchiefs,"

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Hygienic Clothes for Children.—Selection of proper clothing for children is necessary in the promotion of health. The child's clothes should allow freedom to permit the natural growth of bones, muscles, and tissues of the young body as well as to permit the free action of the organs of circulation and digestion. No tight bands, stiff collars nor hard inflexible materials should be used in clothing children. Both ready-made and home-made clothes may provide the necessary health-promoting attributes. The mother is a busy individual, and if she can purchase proper clothing ready-made she will have more time available for the care of her children and will save the exertion of strength and skill in making such garments at home.

Underwear is specially important. It comes next to the skin and plays a vital part in keeping the body at even temperature at all times. Cotton fiber underwear is generally accepted as best for active children, both summer and winter. It should be of soft and open weave, admitting a layer of air within its meshes, thus retaining warmth when the layer of outer garments is added. The open weave absorbs perspiration and oily moisture thrown off by the skin and allows the moisture to evaporate quickly so that the body does not become chilled. It is cheap and is more easily laundered. Linen or flax fiber is smooth and is the

(Continued on Next Page)

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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(Continued from Preceding Page)

coolest in warm weather. Wool, wool and silk mixtures, and silk may be used, but they have some disadvantages.

It is as bad to dress a child too warmly in winter as it is to expose him to the discomfort of cold due to insufficient clothing. If too warmly clad, intense perspiration occurs and may help to produce a common cold. Strong, healthy children do not need to be dressed as warmly as do delicate children or those who may be recovering from illness. Babies, however, must be kept much warmer than older and active children. Mixtures of silk and wool or of cotton and wool are generally used. Thick hems and buttons should be avoided in the baby's underwear because the lumps and ridges make imprints in the tender flesh.

Nightgowns should be designed for comfort rather than for beauty. Soft, warm cotton-fleeced material or flannel is desirable. Collars should be avoided because they wrinkle easily and may cause discomfort. For out-of-door sleeping a sleeping-bag is convenient. The hands and feet are protected and a hood sewed to the neck of the garment prevents cold drafts reaching the back of the neck.

Washable materials are ideal for children's rompers, aprons, dresses, and suits. Materials made of cotton dyed in the yarn and color-set before weaving are desirable. Printed materials do not launder as well. Heavy material, like denim, is useful for coveralls because it stands hard usage. It is tightly woven, however, and does not permit circulation of air and is warm in hot weather.

By selecting proper shoes in childhood much of the foot discomfort found in adults could be prevented. The human foot is a delicately adjusted piece of machinery. In childhood the twenty-six small bones which form its structure, the muscles, nerves, ligaments, and blood vessels, which promote its actions, are soft, pliable, and are easily thrown out of place if cramped in badly shaped shoes.

Flatfoot or fallen arches, corns, bunions, enlarged joints, and calloused places many times have their beginnings in wearing childhood shoes that failed to balance the weight

APPROVED CLINICAL PATHOLOGISTS

American Medical Association Essentials for An Approved Clinical Pathologist

An approved clinical pathologist should be a licensed graduate of medicine. He shall have specialized in clinical pathology, bacteriology, pathology, chemistry, and other allied subjects for at least three years, and he should be reasonably familiar with the manifestations of disease in the body. The director of a clinical laboratory shall be on full time or have definite hours of attendance, devoting the major part of his time to this specialty. A clinical laboratory is an institution organized for the practical application of the fundamental sciences by the use of specialized apparatus, equipment and methods, for the purpose of ascertaining the presence, nature, source, and progress of disease in the human body.

The following Clinical Pathologists directing private laboratories in California are approved by the Council on Medical Education and Hospitals of the American Medical Association:

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of the body, as nature intended, upon the strong, bony, springy arch of the foot. It pays to select children's shoes with great care. As the child's foot develops and grows, the height of the heel should be gradually increased so as to make use of the arch of the foot in supporting the weight of the body. The toes should never be crowded. There should be plenty of room for each toe, but not too much room. The heel should fit snugly so as to prevent twisted and run-down heels. Careful attention to these details may prevent much discomfort as well as acute physical suffering in later years.

Intracranial Hemorrhages in the New-Born.—Hollósi maintains that the etiology of intracranial hemorrhages is not uniform. It is probable that in some of the cases a constitutional abnormality is a predisposing factor to hemorrhage. The symptoms of the intracranial hemor-

rhages vary greatly; only in exceptional cases is it possible to localize the hemorrhage exactly. The treatment of intracranial hemorrhages should be symptomatic. It has not been definitely demonstrated whether the intracranial hemorrhages play a part in the development of diseases of the nervous system during later childhood.

Our chief enemies at present are heart disease, cancer, pneumonia, tuberculosis, and syphilis. If the full facts were known, as Doctor Osler said, syphilis would probably come first. Syphilis is the biggest killing disease in the community. It and tuberculosis are undoubtedly the greatest present contributors to the total mortality prior to the approach of old age. By the removal of tuberculosis and syphilis most of the preventable deaths from the age of 15 to 65 would be avoided.—Sir Arthur Newsholme, M.D.

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I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$_____ to be known as the _____ Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

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FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$_____, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

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FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the _____ Gift, the following described real property situate in the County of _____, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.



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President, California Medical Association

1937

CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 46

APRIL, 1937

NO. 4

SALUTATION FROM PRESIDENT PALLETTE

To the Members of the California Medical Association and their friends, your Officers and Committee Members extend a cordial greeting.

We are most fortunate this year that the Association is holding its sixty-sixth annual meeting in one of the most delightful places in all America. Monterey, this first capital city of California, with its surroundings, constitutes a spot unsurpassed in all the world for scenic beauty, historic interest and facilities for hospitality.

Monterey is the very cradle of Californian history. Viscaino landed here in 1602 and took possession in the name of the King of Spain. In 1821, Monterey became the capital of the Mexican Province of California. The first Constitution of the American State of California was framed here in the first capitol, Colton Hall, still standing, in September, 1849. Other historic buildings still to be seen here are the house of Governor Alvarado, the Presidio chapel, General Sherman's headquarters, the Larkin House, Robert Louis Stevenson's home, the first United States Customs House, and the first theater in California, where many noted actors appeared before and during the days of the gold-rush. Then there are the famous Seventeen-Mile Drive, Pebble Beach, Carmel, and Carmel Mission where Junipero Serra is buried. The numerous unexcelled golf courses in the neighborhood will appeal to many of our members. Hotel Del Monte, the meeting headquarters, has been well referred to as "the world's best-loved resort."

Several objectives are to be aimed at in a meeting of this kind. The opportunity of meeting colleagues and renewing old friendships is most valuable. Doctors who are acquainted are usually good friends. The solidarity of organized medicine is thus increased. Our health, both physical and mental, must be benefited by even a short period of relaxation from the responsibilities of practice. The consideration of the problems of medical economics and public relations is important.

After all, however, the presentation and discussion of the problems of the strictly scientific side of our profession is probably the most important. Much credit is due the Committee on Scientific Program, and to the writers of papers and their discussants for the preparation of the following program. The Section Officers have done their work well.

Those in charge have done their utmost with the hope that you will spend a most comfortable and enjoyable few days at Del Monte. The attendance should be large.

May all Association members, including those of the Auxiliary and their friends in attendance, have a most profitable and a most enjoyable time!

Cordially yours,

EDWARD M. PALLETTE.

California and Western Medicine

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Address editorial communications to Dr. George H. Kress as per address above; advertising and business communications to Secretary-Treasurer, Dr. Frederick C. Warnshuis, also at above address.

EDITOR GEORGE H. KRESS

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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

ANNUAL SESSION, CALIFORNIA MEDICAL ASSOCIATION: HOTEL DEL MONTE, MONTEREY COUNTY, MAY 2-6, 1937

The Sixty-sixth Annual Session of the California Medical Association.—Again a work-year, the sixty-sixth of the California Medical Association, is approaching to its close, to be marked by the 1937 annual session in Monterey County, with central headquarters at the world-famed Hotel Del Monte. As in previous years, attention is called to a splendidly arranged program of interesting events of importance to physicians who practice in California; and all who can arrange their professional responsibilities should make an effort to be in attendance.

It is not necessary to recapitulate the many advantages—professional and fraternal—which members of the Association who join with their fellows in making up the scientific and other assemblies may derive from social contacts and exchange of thought. Physicians who have acquired the annual session habit do not need to be reminded of the benefits and pleasures already and always experienced; but members who never, or only rarely, go to such gatherings may well consider the good to be obtained.

* * *

Scientific Program and Pre-Convention Bulletin Printed in the Supplement.—This year, the scientific program and Pre-Convention Bulletin will be found in a Supplement to the OFFICIAL JOURNAL. The Council approved the plan* for such a supplement in the hope that the new arrangement would not only make for more convenient reference, but bring more prominently to the attention of members the annual session's near approach, thereby promoting a greater and healthier interest, and a larger attendance.

The list of papers announced by the twelve scientific sessions, and the important subjects to be considered, are well worthy of inspection. For those who, in addition to participating in the extensive programs, would have social relaxation, the Monterey Peninsula, with its historical background, its literary associations and scenic lure, offers unusual facilities for recreation.

* * *

Hotel Reservations and Railroad Information.—Hotel reservations have been placed in charge of a central agency—the Hotel Del Monte—acting not only for itself, but for other caravansary establishments in the Monterey district. A list of these hotels is given in the Supplement under the caption, "Hotel Information." Members, therefore, who have not yet secured reser-

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

* See Council minutes, March, 1937, page 189, item 2.

vations, and who plan to go to Del Monte by auto, should look over the names in advance. Under the heading, "Railroad Information," are given the schedules in operation at this writing; but since new time tables are anticipated about April 1, check should be made on the announcements at the time when tickets are purchased. A reduced rate will be available, but only for those who, through their respective county society secretaries, secure in advance the proper transportation slips.

The group of distinguished guest speakers who will come from other states to address the general and special meetings, the scientific programs of broad scope, and also the entertainment features, should make the Del Monte annual session of May 2-6, 1937, measure up to the highest standards of conventions ever held there. The officers of the Association sincerely hope that the session will be marked by both banner attendance and a record of much good work accomplished.

STATUS OF BILLS BEFORE THE LEGISLATURE

Two Hundred and Fifty Public Health Measures.—In previous issues it was stated that, among the 4,000 bills submitted to the Fifty-second California Legislature, now in session, more than 250 deal with public health matters. These bills were introduced in the month of January; and at this time, in the third week of the second period of the legislative session, are under consideration in some twenty-four committees. It is not possible, therefore, to prognosticate their ultimate fate; and until the Legislature adjourns it will be as important as ever for all County Committees on Public Policy and Legislation to be alive to their responsibilities when called upon for aid by the State Committee. For the information of members we append some notations compiled from reports received from the Committee on Public Policy, showing the status of some of the measures at the time of this writing:

County Hospitals.—Assembly Bill 51, by Assemblyman Heisinger of Fresno, which would open up county hospitals, was tabled by the Assembly Committee on County Government, following a hearing on March 16. Through the Association of California Hospitals, powerful opposition was registered with the committee and the bill was tabled. There are two remaining county hospital bills to be considered at a later date. A Senate Constitutional Amendment, No. 5, which would submit the subject of wide-open county or city hospitals to the people for a vote, will be considered by the Senate Committee on March 25.

Code Bills.—The bills prepared by the California Code Commission, to codify the existing laws relating to Medical Practice, Dental Practice, Nursing, Trained Attendants, Ophthalmia Neonatorum, and Medical Library, have been favorably reported by the Senate Committee, and are now before the Senate for passage.

Optometry Bills.—On March 15, there was a lively fight in the Assembly Committee on medical and dental laws, concerning Assembly Bills 1137 and 1143, inclusive, introduced by the State Board of Optometry and the Optometry Association. Through strenuous opposition, it was possible to amend out provisions which invaded the practice of medicine and gave extended rights to optometrists. Along this same line, Assembly Bill 1676, providing for a division in the State Department of Education to set up audiometer tests in all school districts, was satisfactorily amended.

Osteopathic Bills.—The osteopaths have been especially active during this session of the Legislature, and their committees called upon practically every member of the Legislature during the February recess. There are a number of bills which relate to this subject, and Assembly Bill 1880, giving osteopaths the right to serve as physical inspectors in schools, is set for a hearing before the Assembly Committee on Education on March 23.

Chiropractic Bills.—The chiropractors, also, have been active, this time in behalf of a constitutional amendment to extend their powers. This comes up for final hearing in committee on March 22. The Naturopathic Bill is still resting in committee.

Health and Hospital Insurance.—No action has been taken in committee on the Williams Bill (Senate Bill 121) or the McGovern bill (Senate Bill 605). The Williams bill has been set for hearing before the Senate Committee on Insurance on March 29. Assembly Bill 1132, sponsored by the Association of California Hospitals and designed to provide hospitalization insurance, has been extensively amended by its sponsors and will come up for hearing during the coming week. (Later: on March 29, the Hospital Service Bill passed the Assembly, with a vote of 64 to 0, and without any additional amendments.)

Venereal Disease Bills.—There is much interest in the venereal disease control bills. Assembly Bill 1089, introduced by fifteen Assemblymen, has been substantially amended. Assembly Bill 2790 is sponsored by the State Board of Public Health. Assembly Bill 2569 (the G-S bill) is sponsored by Assemblyman Richie of San Diego. All of these bills will be heard before the Assembly Committee on Public Health and Quarantine on March 24.

Nursing.—Assembly Bill 2125, of interest to nurses, has been withdrawn from the calendar of the committee, with the report that interested parties are getting together outside of the Legislature.

Compensation Act Amendments.—There are a number of bills amending provisions of the Workmen's Compensation Act, and some of these would give the injured employee free choice of any licensed healer (not confined to M. D.'s). But determined opposition has brought about postponed consideration of these until April 2.

At the Del Monte annual session, on May 3, Dr. Junius B. Harris of Sacramento, Chairman of the California Medical Association's Committee on Public Policy and Legislation, will present a progress report.

NEW FEATURES IN COUNTY MEDICAL SOCIETY MEETINGS

County Society Programs Should Be of Broad Scope.—The order of business at meetings of many County Medical Societies has varied but little with the passing years; the generally accepted plan being the reading and discussion of one or two didactic papers on medical topics with which, at times, are given some reports of cases and a brief consideration of business items. The tradition of constancy to this type of program has been so firmly instilled that, when attempts are made to introduce the consideration of important, modern-day problems having to do with medical economics, not infrequently the suggestions are received with silent or outspoken opposition.

Such conservatism and allegiance to former procedures, however, are not everywhere prevalent, and less so, perhaps, in the Far West than in the East. As throughout the Union some of the pressing economic and social welfare problems begin to make themselves felt in medical practice, there are indications of an increasing willingness to permit discussion of matters closely related to medicine's progress, even when these encroach only indirectly on scientific medicine. It is fortunate that an alteration of attitude has come about, because, in this changing, present-day world, with the emphasis that is being placed on regimentation, and on mass and stereotyped production, it is apparent that institutions, organizations and individuals who do not recognize these newer forces may find cause, later on, to regret their indifference or opposition. It is becoming increasingly evident that State and County Medical Societies, through perhaps their official publications, must call the attention of members, not once, but repeatedly, to problems directly or indirectly affecting medical practice, and concerning which it is important to have unity of opinion and collective action. Only through frank discussion and subsequent agreement on courses of action to be pursued, may we hope for successful outcomes in some of these matters which so threaten medical practice and the interests of physicians. In this connection, it is gratifying to note that medical schools also are awakening to their responsibilities to young men and women, by them in the past so often launched into professional practice, saturated presumably with medical knowledge and idealism, but with little or no comprehension as to just what they may be apt to meet in a practical world, or along what lines it would be wise for them to guide their courses if mistakes or blunders, that might prove handicaps for years, were to be avoided.

Fraternal Contacts and Understandings Should Be Encouraged.—Somewhat of the lack of acceptance of these nonscientific portions of medical practice has its basis in the inadequate attention which societies have given in the past to fraternal affiliations between members; it being forgotten or minimized that, through such social fellowship, come better, broader and kindlier understandings, ends much needed in a profession where individualism plays so vital a part in daily living and practice. For instance, that is why dinner meetings, preceding or following scientific and business sessions of County Medical Societies, can be made to have great value. It is encouraging to note the increasing number of medical organizations beginning to appreciate this. In the larger societies, especially, additional features may be brought forward to promote good fellowship, as well as the concord of purpose that comes from better personal understanding and friendship with colleagues whom one might otherwise know only by name, or in the most casual manner.

* * *

Two Recent Novel Features Sponsored by the Los Angeles County Medical Association. Reference may be made, in this connection, to two recent activities which have created much interest in the Los Angeles County Medical Association. One was the Hobby Exhibit, described on page 134 of the February issue of CALIFORNIA AND WESTERN MEDICINE, in which more than forty members presented exhibits of their activities in nonmedical art and work, by displaying things they, themselves, had made or collected. It was the opinion of the many visitors to the "hobby show" that it rendered a most useful service, not only to the County Association and its members, but, through publicity given in the daily press, also to the community.

On page 286 of the current issue appears a story of an "Amateur Night" which was marked by the largest attendance yet recorded since the new headquarters of the Association have been used, the audience consisting of almost six hundred physicians, each of whom enjoyed the talent displayed by fellow members, and voted the evening's entertainment a great success. Mention may also be made of the Bridge Tournament, which was carried on during the noon hours throughout the year. An account of this, with a description of the President's Perpetual Bridge Trophy, is given on page 282 of this month's issue.

The officers of the Los Angeles County Medical Association, therefore, are of the opinion that these new forms of Society activity have been of aid in strengthening the Association, and they propose to continue efforts along such lines.

* * *

Medical Societies Should Promote Scientific, Organization and Fraternal Activities.—There is as much need today as ever for support of all plans that make for the advancement of medical science, but it is an error to think that component county units in the United States—upon whom,

through collective action, falls much of the burden of maintaining, in their own territories and at large, the standards of scientific medicine—can be true to progress in medical science only by remaining aloof from relationships essentially human and fraternal.

As a matter of fact, in every County and State Medical Society, scientific, and also organization and fraternal, activities should be given proper places. There is a real demand for each, and a study of societies will reveal that those associations which give each of these elements their due recognition are accomplishing the best work for medicine, the public health, and for themselves.

“THROW AWAY” PUBLICATIONS

Minnesota Medicine Calls Attention to a Growing Evil.—A letter from the editor of *Minnesota Medicine*, on page 202 of the March, 1937, issue of *CALIFORNIA AND WESTERN MEDICINE*, called attention to the manner in which so-called “throw away” publications—sent out by the thousands for distribution to physicians throughout the Union—were abstracting, without permission, article after article which had previously appeared in State Society and technical journals. The Minnesota Committee on Publications stressed the importance of recognized medical magazines copyrighting their articles, in order to prevent these bold and unwarranted forays upon their contents. Several of these publications (with a no-subscription price, but distributed-free background) that have come into existence during the last several years, state in prominent type that more than 100,000 copies of their current issues had thus been placed in the mails.

The character of the advertising carried in most of these magazines is much like that which appeared, some twenty-five years or more ago, in a group of proprietary medical journals, the majority of which later went out of existence. As a consequence, for about two decades, the advertising pages in medical publications have been of comparatively decent standard, because of the nonexistence of periodicals which would accept advertising copy from the promoters of remedies whose formulae were not known or accepted by responsible investigators, such as the Council on Pharmacy of the American Medical Association.

* * *

Character of Advertising in These Newer Publications.—Come now, and rather of a sudden, not one, but almost a dozen of this new type of journal, in which all kinds of advertising seem acceptable, and as a consequence of which the announcements of all kinds of nonapproved remedies are freely interspersed with the abstracts of articles, written by physicians of established reputation, whose original papers appeared in well-recognized medical journals. It is possible that the increasing number of such magazines may

ultimately make for their disappearance, on the natural supposition that firms which would present for consideration only drugs and remedies proven and acceptable to scientific and ethical medicine would no longer wish to be associated, page to page, with promoters of remedies not endorsed by the American Medical Association's Council on Pharmacy.

* * *

“California and Western Medicine” Is Protected by Copyright.—The California Medical Association, through its Council in the year 1934, took out a copyright, and on a number of occasions the attention of several of these more recent periodicals has been called to their violation of that legal protection. Members, therefore, will confer a favor upon the central office of the California Medical Association if they will notify the Association Secretary whenever and wherever they detect such abstracting by irresponsible journals of articles previously and originally published by *CALIFORNIA AND WESTERN MEDICINE*. The California Medical Association gladly extends to state medical publications and others recognized in the specialties and of acceptable standard, the right to quote from and to make extracts of the contents of the *OFFICIAL JOURNAL*. Through its copyright protection, however, it again gives notice to all other periodicals, particularly to those of the “throw away” type, that the right to print any part of its contents, in abstracts and excerpts, is strictly forbidden.

EXCESSIVE FEES: THE HARM THEY DO TO SCIENTIFIC MEDICINE

What Newspaper Publicity Has Done.—Publicity in newspapers concerning suits over excessive fees has been a big factor in creating, among many estimable citizens, a prejudice against the medical profession; and one of the regrettable effects of such discussion by laymen can be noted in the support which is so militantly given by some civic organizations to various proposed legislation. Among such propositions are those which would open to nonindigent persons, on a part-pay basis, the doors of public institutions maintained for the indigent sick; the sponsoring of compulsory health insurance laws; and the support of voluntary health insurance measures, these last sometimes so loosely drawn that the medical protective feature (presumably of ample amount and types, as well as mandatory) is more a matter of assurance on paper than real security, and little less than a trespass upon the credulity of the unfortunate holders of policies.

In the late nineties and years immediately following, before the Carnegie-Flexner survey of medical colleges of the United States and prior to the surprising legal recognition of cultist groups by some of the States (of which California was one), comparatively little was seen in the daily press on the subject of excessive fees for medical and surgical services.

The Graduates of Smaller Colleges of Former Days.—Looking backward, however, it is to be noted that those were days when the graduate of a smaller or proprietary medical school was apt to be looked upon somewhat askance, or as one of a group of practitioners whose authority of licensure went far to lower the tone of medical standards; and this opinion held with many, in spite of the fact that many eminent in medicine had been, and were, graduates of just such small institutions—their mental capacity and love of the art ultimately giving this group a place, side by side, with leaders in the profession whose undergraduate years had been spent in more favored university schools. It is true that during the last twenty-five years the standards of medical education have been greatly advanced, so that the graduates of today go forth with far more science at their command than their predecessors of two or more decades ago. Yet, in the practice of medicine, mere knowledge of facts is not the end, an equally important element being the capacity to think clearly and to apply the knowledge possessed in logical, scientific manner, and with true art.

* * *

More Than Professional Training Alone Is Needed to Produce the True Physician.—It must be remembered that every medical student and physician is himself, before he is a doctor of medicine, and that no matter what knowledge he may acquire, his basic character will temper his professional work and tone. When then, occasionally, a licensed practitioner, who has had excellent professional training, places commercialism before service (as is manifested, for instance, in fees so high that they are out of all proportion to those asked by colleagues of equal ability, and for services of a similar nature), a real hurt is done to the medical profession of the community in which the offending individual practices; and for an older practitioner to commit such an act only makes the offense the greater. In view of the damage done to medicine by individuals having these supercommercialistic tendencies, it may be asked whether it would not have been better had they never taken up the practice of medicine, but used all their talents in the business world, where search for profits is not associated with a profession inspired by altruistic obligations; and, also, whether such physicians have not done more to lower the esteem in which the medical profession was held in former years than did, in earlier days, the graduates of small proprietary medical schools (whose places in both rural and urban centers have been taken by cultist practitioners).

* * *

A Case in Point.—These reflections are engendered by a recent newspaper item concerning a licensed physician in California who sent a well-known actor a statement for medical services, and demanded in excess of ten thousand dollars; and when the patient refused to pay, the physician entered suit, with the result that the newspapers promptly played up the item for the edification of

their readers. Immediately, and on all sides, were heard words of condemnation for the physician who had rendered the bill. And what made the case, from the standpoint of organized and scientific medicine, the more deplorable, was the fact that the medical man who rendered the twelve-thousand-dollar statement was cited several years ago to appear before the State Board of Medical Examiners (subsequent to a court trial on a narcotic charge that then received much publicity in the newspapers), when the Board, after its hearing, revoked his license. As might be expected, the physician thereupon appealed to the Superior Court, only to have the Court sustain the Board of Examiners, although later the Board, in 1934, restored the practitioner's license while placing him on probation with certain stipulations; which restrictions, at the time this is written, stand. And now comes this later exploitation of a fee of some twelve thousand dollars, which this same physician construed as a proper return for the care of a patient through an illness of not over-great duration. Here, surely, is an instance where it is impossible to estimate the damage done by the wrong kind of publicity!

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 267.

EDITORIAL COMMENT†

THE TREATMENT OF HEMORRHAGIC DISORDERS*

The diagnosis of hemorrhagic disorders involves a careful study of the capillaries, the plasma, and the platelets. Abnormal bleeding is due to disturbances in capillary permeability with or without alterations in the plasma or platelets. Rational treatment depends upon the proper assessment of the part played by each factor in abnormal bleeding.

Clinically, hemorrhagic disorders may be divided into two main classes, hemophilia and purpura.

In hemophilia the primary fault is in the plasma. The platelets fail to lyse readily. Extravasation of blood occurs when the capillary permeability is increased. This usually follows upon trauma.

Purpura is divided into hemorrhagic purpura, characterized by the escape of whole blood from blood vessels and mucous membranes, and anaphylactoid purpura, characterized by diffuse bleed-

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

* From the Division of Medicine, University of California Medical School, San Francisco.

TABLE 1.—*Findings in Certain Hemorrhagic Diseases*

	Capillary Resistance	Bleeding Time	Coagulation Time	Clot Retractivity	Platelets Numbers	Platelets Lysis
Thrombopenic purpura	Diminished	Prolonged	Normal	Poor	Diminished	Normal
Non-thrombopenic purpura..	Diminished	Prolonged	Normal	Poor	Normal	Normal
Thrombasthenic purpura	Diminished	Prolonged	Normal	Poor	Normal	Increased
Pseudothrombophilia	Normal	Intermittently prolonged	Normal	Occasionally poor	Normal	Normal
Hemophilia	Normal	Normal	Prolonged	Normal	Normal	Diminished

ing from mucous surfaces, ecchymoses, and swellings containing plasma. Purpura of any type may or may not be associated with a diminution of platelets.

Findings in Certain Hemorrhagic Diseases.—These are outlined in Table 1.

The Capillaries.—Capillary permeability is increased in certain allergic conditions: vitamin B and C deficiency; infections, especially those due to streptococci; chemical poisoning due to drugs having a vasculotoxic effect, *i. e.*, arsenic, benzol, gold, benzamides; after large doses of venom; and in hereditary defects of the vascular endothelium.

Capillary permeability may be altered by immunization with moccasin snake venom; administration of calcium and parathormone; induced hypersensitivity to hen or sheep sera; intravenous administration of cevitic acid; and by the intramuscular administration of antivenin.

The Plasma: Bleeding is favored when the plasma is deficient in prothrombin, fibrinogen, or calcium. When blood is shed, the thrombokinase liberated by disintegrating platelets assists in the formation of the thrombin clot. Only a few platelets are necessary for the coagulation of blood, but many are needed in order to have proper clot retraction.

Prothrombin and fibrinogen may be altered by diets high in protein and fat. Transfusions, intramuscular whole blood, styptysate, and the parenteral inoculation of various blood sera alter the plasma in such a way as to inhibit bleeding. Exposure to x-ray acts similarly.

For local bleeding, the usual hemostatics, adrenalin on cotton, fresh blood on cotton, the application of fresh muscle tissue, styptysate, fibrinogen, thromboplastin, and cobra venom, are at times effective.

The Platelets: The problem of the genesis and function of the platelets is not yet settled. In normal blood their numbers vary from 150 to 900 thousand per cubic millimeters, depending upon the method used in counting them. It has been stated that they represent the remains of intravascular debris derived from the breakdown of blood cells and vascular endothelium. They are a source of thrombokinase, and act as a cement substance to barrier the flow of blood through pathologically permeable capillaries.

The platelets may be increased after transfusion, intramuscular inoculation of whole blood, autohemotherapy, inoculation of foreign protein,

ultra-violet irradiation, exposure to x-ray, and splenectomy.

In emergencies, transfusions or the intramuscular inoculation of whole blood offer the best means for controlling hemorrhage.

University of California Medical School.

S. P. LUCIA,
San Francisco.

Individuals, sometimes getting out of patience with our complex modern life, would return to a simple order of things. Rousseau advocated going back to nature, urging people to lay aside artificiality and compose themselves in a kind of primitive state. His plan was admired, widely discussed, but not put into practice; for society, like time, never moves backward. We can no more return to an earlier condition than the old can become young. Reform, as well as development, goes forward. The car of civilization ascends or descends, but has no reverse gear.

Treatment of Obesity in Children.—Mallam is convinced that dieting is the keystone to treatment in almost all cases of obesity in children, but before prescribing a system of diet a careful family history and knowledge of conditions under which the child is being reared must be obtained. Obesity beginning in childhood often gives rise to endocrine trouble later on, and when one finds a strong dominant obesity factor in the family, one should always be prepared to face a more difficult task than in a purely fortuitous case arising from normal stock. Even then, however, a cure, permanent and complete, can be obtained in the majority of cases by simple measures. The treatment must be explained carefully to the child and need not be elaborate. A simple practice is to weigh and measure the child and give it a diet based on the calculated basal requirements for this particular height and size. This is merely a beginning figure, and it may be necessary either to add to or subtract from the initial starting point. The question of the fluid intake is of considerable importance. If these children are counseled to drink early in the morning and then to try not to drink at all through the day, this is often a great help in reducing weight. Appetite is largely a question of satiation, and these children must be schooled to eat slowly. Salt and sugar should be cut down to a minimum. Many children appear even fatter than they are because of postural defects. Exercises devoted to training the recti abdominis and correcting any possible lordosis and to making them stretch their overloaded limbs are all valuable. Such exercises are always more effective under trained supervision and are usually better done in a class of several children. Some sort of abdominal support employed temporarily often gives considerable help. At the same time strengthening exercises are absolutely essential, for without them one must either rely on artificial means or face a serious chance of visceroptosis. If a child loses weight consistently under treatment, the treatment is being overdone. If one treats an overweight child of ten years and at twelve the child weighs the same, one should realize that a great deal has been achieved.—*Clinical Journal* (London).

ORIGINAL ARTICLES

LYMPHOMATOID DISEASE: HODGKINS AND LEUKEMIC TYPES—THEIR TREATMENT*

By H. J. ULLMANN, M.D.
Santa Barbara

DISCUSSION by Irving S. Ingber, M.D., San Francisco; William E. Costolow, M.D., Los Angeles; Raymond G. Taylor, M.D., Los Angeles; John C. Ruddock, M.D., Los Angeles.

A GREAT deal has been written on the treatment of the leukemias and lymphoblastomas by radiation. It is only in the last few years, however, that radiologists, to whom these sufferers must look for relief, have begun to consider the patient as an individual instead of a case for such or such dose or course of radiation. This paper is written as a plea to consider each case as a separate problem, and that no radiologist who is not also a clinician is qualified to treat them. This is essential, because if the best results are desired from radiation therapy, the radiation therapist must be in charge of the patient. The plea of the internist, that the radiologist is not qualified to decide anything but the size of the dose of radiation, if true, disqualifies that radiologist from treating the patient, and the referring physician is responsible for sending his patient to an incompetent therapist for treatment of a disease requiring the highest type of clinical judgment if life is to be prolonged.

PRINCIPLES OF TREATMENT

The scope of this paper and the time allotted for its presentation are too short for even an attempt to cover the subject. Nothing will be said regarding details of radiation technique such as regions to be treated in the various types of cases, for they are well known to competent radiologists. It is desired to present what the author believes are the proper principles of treatment, and what may be summarized as follows: The patient must be considered as an individual with a disease, and one differing in major or minor degree from every other individual with the same disease. The radiation, because these diseases are not curable, must be the smallest in amount that will produce beneficial results. Single doses, as small as 50 r, measured on the skin will often produce the effect desired when larger ones would shorten life. Size of dose and intervals between radiations must be determined by the patient's condition and response to previous treatments. As many of these patients live for years under proper management, copper filtered radiation or its equivalent should be used where possible to prevent eventual skin injury. Repetition of treatment should be determined by laboratory findings rather than clinical symptoms. An increase in the mediastinal shadow calls for treatment long before there are clinical symp-

toms. A change in the blood count, quantitative or qualitative, should be a warning even if the patient feels well or no enlargement of spleen or lymph nodes can be felt. While radiation is the primary method of treatment, others must not be forgotten. Diet must be regulated, occasional drugs prescribed and, of prime importance, the morale of the patient maintained.

REPORT OF CASES

Two cases will be discussed to illustrate the application of these principles—a Hodgkin's disease and a lymphoid leukemia.

CASE 1.—The patient with Hodgkin's disease was a boy of twelve years when first seen at the Mayo Clinic. For a year previously he had been treated for tuberculous adenitis, without improvement. He was referred to Doctor Desjardins for radiation therapy in February, 1925, with the diagnosis of Hodgkin's disease. The regions treated were the right and left cervical, infraclavicular, axillary and inguinal. Also the mediastinum and prevertebral lymph tracts, all at 135 K V P through 4 millimeters of aluminum. A second course was given in March, and in April a third to the cervical and axillary regions only. In July only a few very small nodes could be found in the supraclavicular spaces, and these received a fourth treatment. His family moved to Santa Barbara and he came under my care in August, 1925. No radiation was needed until March, 1928, when nodes were palpated in the cervical, axillary and inguinal regions. These were treated at 130 K V P through 0.25 millimeters of copper plus one of aluminum between March 28 and April 9, 1928, inclusive. A check of the mediastinum showed a broadening of the shadow, and this was treated at 200 K V P through Cu 0.5 plus Al 2.0 millimeters. In December, 1929, the inguinal and axillary regions were irradiated, and again in June and December, 1931, and May and December, 1932. These last consisted of single irradiations of small nodes. In March, April, and May, 1933, occasional irradiations to the mediastinum were given, and again in June and July, 1934. The mediastinal nodes became more resistant (or perhaps more apt to enlarge) and required treatment again in February, April, and May, 1935. Continuous though intermittent mediastinal radiation has been required to the present time to control a tendency of the mediastinal shadow, not only to broaden, but to infiltrate, and lately it has been impossible to obtain a complete clearing.

In spite of this, the young man feels entirely well and has been so throughout the time he has been under observation. At no time were nodes allowed to develop to the point of producing symptoms or even of attracting the patient's attention. He attended school regularly, and was graduated from Stanford and is now working. He reports regularly for examination, and accepts treatment whenever he is told that it is needed.

CASE 2.—The second case is that of a man with lymphoid leukemia. He was sixty-three years old when first seen in June, 1931. He had had enlarged cervical glands since 1922. He said that they had enlarged and regressed several times, and that he did not feel so well during the enlargements as during the regressions. A diagnosis of mononucleosis had been made at the Rockefeller Institute in December, 1930. The spleen was not palpable. There was a generalized absorption of the alveolar processes, with multiple alveolar abscesses and slight but constant bleeding from the gums. Hemoglobin was 78 per cent; red, 4,050,000; white, 34,100; small lymphocytes, 92 per cent; large lymphocytes, 4 per cent; polymorphonuclears, 3 per cent; eosinophils, 1 per cent.

The chart shows the progress of this case under treatment. Toward the later stages more attention was paid to the total polymorphonuclear count than to the total white count in deciding on both the time of the irradiations and their amount. Because of the oral sepsis and his procrastination in having the teeth removed, it was

* From the department of cancer research, Santa Barbara Cottage Hospital.

Read before the Radiology Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25 to 28, 1936.

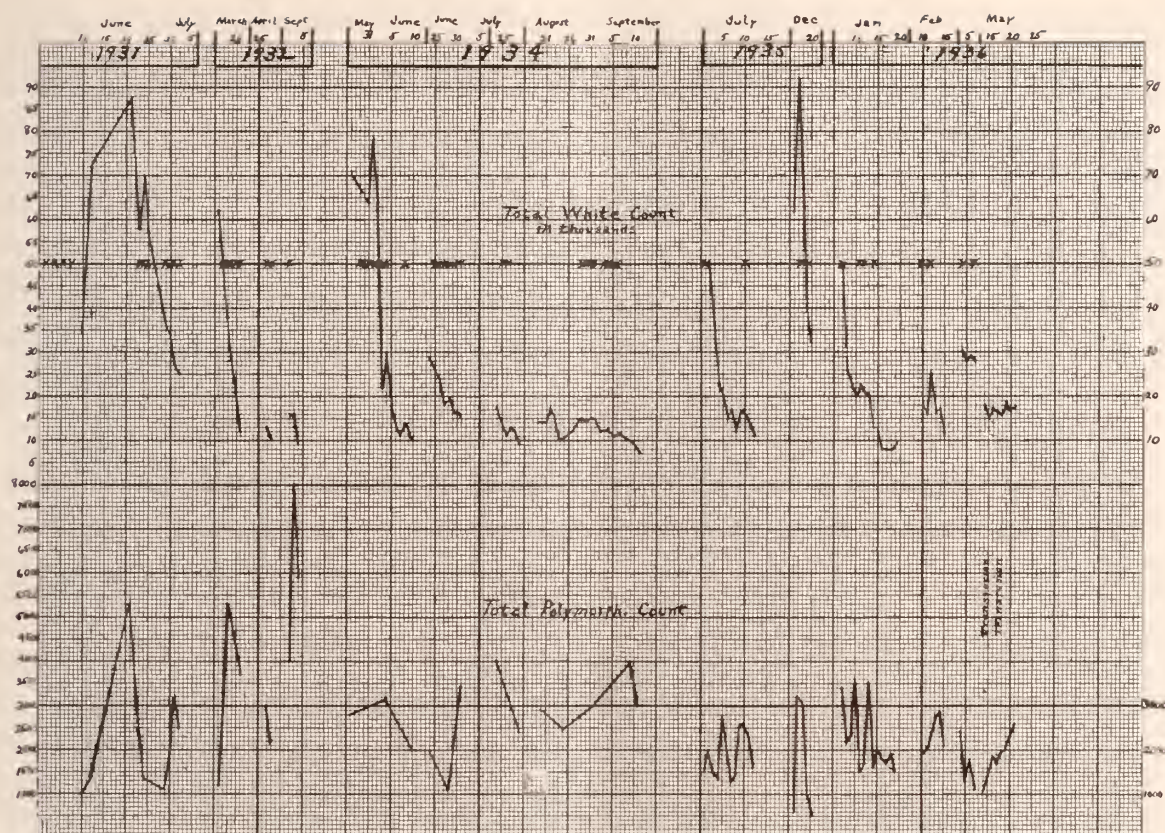


Fig. 1.—Lymphoid Leukemia.
X=radiation

felt that a reasonable polymorphonuclear count was of more importance than the height of the total count. He was repeatedly urged to have his mouth cleaned up and always promised to do so in the future, but never did. It was felt that the oral sepsis was the immediate danger point. This month (May, 1935) he had an upper incisor extracted with immediate extension of the sepsis into the roof of the mouth. There was considerable necrosis. The total white count was moderate, but the polymorphonuclear count alarmingly low. The beneficial effect of blood transfusions on the polymorphonuclear count may be seen on the chart. As the polymorphonuclears increased, the oral neurosis became demarcated and finally began to heal. With the remaining teeth set in extensive abscesses and the count as shown, I leave it to your imagination what the outcome will be. This chart is shown to illustrate how the blood picture can be controlled by small repeated irradiations over a long period, and how it is also necessary to use other methods as indicated; in this case oral hygiene (a failure from lack of cooperation) and blood transfusions.

IN CONCLUSION

I believe that if these principles, requiring both clinical judgment and knowledge of the effect of radiation, are followed, the average life of patients with these diseases may be considerably lengthened.

1520 Chapala Street.

DISCUSSION

IRVING S. INGBER, M.D. (490 Post Street, San Francisco).—Lymphomatoid disease being chronic, progressive and incurable, one must, in treating these conditions, utilize all of his talents in the prolongation of life with the greatest degree of comfort to the patient.

To attain this objective, we should bear in mind that lesions may occur wherever lymphoid tissue exists; and having this in mind, one will not be confused when con-

fronted with rather unusual complications which happen not infrequently.

Doctor Ullmann has rightfully stressed the importance of utilizing the smallest possible dose of x-rays consistent with beneficial results. The reasons will appear quite obvious to the experienced radiologist.

The lesson to be learned from Doctor Ullmann's second case is the importance of a complete survey of the patient in the beginning, especially in reference to locating all possible sources of focal infection, and eradication of the foci as quickly as is consistent with the patient's condition; and, finally, periodic examinations of the blood in order to maintain a clear conception of the progress of the case.

✽

WILLIAM E. COSTLOW, M.D. (1407 South Hope Street, Los Angeles).—Doctor Ullmann has brought up some very valuable points in connection with the treatment of leukemias and lymphoblastomas by radiation. The idea that the radiation therapist should be qualified to control the clinical aspects of the case is a good one, as the treatment of these conditions is almost entirely radiologic. The day is rapidly passing for the diagnostic roentgenologist to give treatment under the direction of the internist, who is unfamiliar with the action and effects of radiation. The radiation therapist is a new type of medical specialist who is rapidly establishing himself in the field of cancer and diseases treated by radiation because he must know the clinical phases of these diseases, as well as be familiar with the action and effects of radiation agents.

In the lymphomatoid diseases the aim of therapy is almost entirely a palliative one. In order to produce the longest possible palliation, it is important that not only the general condition of the patient be maintained, but also that skin reaction be avoided so that the radiation treatment can be repeated at intervals for a long period of time. The small doses of copper-filtered radiation advised by the author are very essential.

In general, in the leukemias, the chief indication for additional radiation therapy is the increase in the percentage of the immature forms of blood cells. These findings must be correlated with the total white count and

another most important factor—the general clinical condition of the patient. Although in the early stages of the disease prompt remissions are obtained, the life of some of these patients may actually be shortened by overzealous radiation treatment improperly prescribed.

The lymphoblastomas so simulate highly malignant diseases in their clinical course and response to treatment that one familiar with the palliative radiation treatment of cancer may greatly alleviate the suffering of these patients, and actually prolong their lives many years.

✽

RAYMOND G. TAYLOR, M.D. (1212 Shatto Street, Los Angeles).—Doctor Ullmann's plea for individualization in treatment of these conditions is certainly well taken. However, I feel that one should not get the impression, possible from his paper, that individualization means necessarily small doses. In our own experience, we have had a number of patients who did fairly well, over a long period of time, with fairly large doses—not very often repeated.

Doctor Ullmann reports he had remarkable coöperation in Case 1; and it would seem as though this was an ideal case for the small-dose method that he advocates, and he is to be congratulated on the result. However, the best of coöperation is not often obtained, as he notes in his Case 2.

We have had one patient, as I recall, who absolutely would not return for treatment until she got into a very distressing condition. This was a Hodgkin's, and the lesions were chiefly in the neck and mediastinum. Fairly large doses were necessary to accomplish anything with her at any time. However, we were able to keep her alive and useful (she even went through a pregnancy successfully) for over nine years, but finally died after going East.

I should be interested if Doctor Ullmann would tell us if his patient in Case 1, which had so many treatments and over such a long period of time, has had skin reactions or changes that are still evident.

So far as our experience is concerned, the time comes with all these patients when the lesions become radio-resistant, and then I think larger doses can be used with some benefit. However, the progress of the disease, after evidence of increased radio-resistance in the lesions, is almost invariably down hill and usually rapid.

✽

JOHN C. RUDDOCK, M.D. (1930 Wilshire Boulevard, Los Angeles).—Doctor Ullmann's paper on the treatment of lymphomatoid disease is a timely one, and it is refreshing to note that he stresses the point that radiologists are considering the patient as an individual rather than a case for such a dose or course of radiation. Lymphomatoid disease is incurable at this time, although it is agreed that it is possible to prolong life by means of radiation. These cases, however, fall within selected groups. We must not lose sight of the fact that although the pathologist has given us a biopsy report of lymphoma, the end-result may be Hodgkin's disease, leukemia, or lymphosarcoma. The prognosis in each of these three types is somewhat different. Leukemia may be either acute or chronic, prognosis in Hodgkin's disease would depend upon the structural involvement, while the prognosis of lymphosarcoma is a very grave problem. Doctor Ullmann reports presence of profound mouth infection in one of the cases. This is merely one instance of things that may happen in cases of this character.

Patients are naturally desirous of living as long as possible, and so demand comfort. In the treatment of cases of this character much can be done toward increasing the longevity and the comfort of life of the unfortunate patient affected by a complete understanding between the radiologist and the patient's physician. Judgment is paramount, and coöperation and coördination of treatment among all those concerned are necessary if the welfare of the patient is to be considered.

✽

DOCTOR ULLMANN (Closing).—I agree with Doctor Taylor that individualization does not necessarily mean small doses. There are instances where the dose should be increased, but as a rule these are the exceptions. I can only emphasize my statement that clinical judgment in treating these patients is essential.

There are never any skin reactions when the small-dose method is used with heavy filtration. In fact, reactions would preclude such continuous treatment. In the patient with Hodgkin's disease the skin over the mediastinum is now showing some dryness and tan, but this has always disappeared whenever there is a long interval between treatments. Of course, he was warned not to take sun baths and to keep the chest covered when on the beach.

I am in accord with Doctor Ruddock that the best interests of the patient are served when there is complete coöperation between the internist and the radiologist. Unfortunately, in practice this does not always occur, as each physician assumes the other is watching the patient and the internist too frequently exercises his own judgment, regarding further treatments, without consulting the radiologist. This often results in postponement of treatment beyond the point where the greatest benefit would accrue.

TOXEMIAS OF LATE PREGNANCY*

By JAMES V. CAMPBELL, M.D.

Oakland

DISCUSSION by H. A. Stephenson, M.D., San Francisco; L. Grant Baldwin, M.D., Pasadena; John W. Sherrick, M.D., Oakland.

IN reading the literature on the toxemias of pregnancy, one is always rather alarmed by the high incidence of mortality, both maternal and fetal. Maternal deaths in eclamptics vary in different reports, but in this country they average about 20 per cent and fetal mortality ranges from 3.62 to 42 per cent.^{1,2,3} While much has been done to better the general welfare of pregnant women, "no substantial decrease has been made in the death rate due to toxemias and chronic nephritis."⁴

The next factor which stands out is the great variety of etiologic factors that have been suggested and the strictly empiric or symptomatic treatment resorted to.

A third observation which seems significant is the apparently definite relationship of the early toxemias to the late toxemias. This will be discussed later in the paper.

The present report represents 168 women, who developed signs and symptoms of toxemia, in a series of 4,979 consecutive deliveries in the private practice of several physicians—an incidence of 3.35 per cent. Other reports give a higher percentage of toxic patients, but their definition of beginning toxemia varies somewhat from this one especially as to what constitutes elevated blood pressure.

PATIENTS INCLUDED IN THIS STUDY

Any patient who developed a blood pressure of 150 systolic or over, or showed other definite signs or symptoms of toxemia such as albuminuria, edema, persistent headaches, etc., was included in the study. If she had edema of the lower extremities only, with no other evidences of toxemia, she was not included because it is felt that edema of this nature is due to pressure with a resultant poor return circulation. No cases of acute yellow atrophy were encountered. Five patients who had primary arterial hypertension or "essential hyper-

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tension" were included. These individuals had their hypertension when first seen, but no other indications of toxemia developed while under observation.

The term "eclampsia," as used in this paper, indicates the presence of true convulsions or coma. Preëclampsia means the nonconvulsive toxic patient.

AGE INCIDENCE

The age incidence varied from 18 to 45 years, with an average age of 30.2 years. In most articles on toxemia it is noted that there is a marked preponderance of primiparae, and this report is no exception. Primiparae accounted for 114, or 68 per cent, of the toxic patients. Of the fifty-four multiparae, twenty-seven (50 per cent) had had toxemia during their first gestation, and five of these patients were toxic for a third consecutive pregnancy. Other writers³ also report that 50 per cent of toxic patients develop toxemia in subsequent pregnancies.

Adequate prenatal care in the majority of cases is indicated by the fact that these patients were under observation on an average of five months, and their average weight gain was only twenty-two pounds, which is within normal limits.

TREATMENT PROCEDURE

A fairly uniform type of conservative treatment was tried as soon as the first signs of impending toxemia appeared. Depending upon the severity of the disease, the following routine was followed: (1) rest (restricted activity, bed rest, or hospitalization); (2) diet (salt-free, low protein, forced fluids, fruit juices, milk); (3) elimination (citrate of magnesia, colonic irrigations, or magnesium sulphate either by mouth or intravenously; (4) alkalization; (5) quite frequent use of nephritin; (6) sedatives. Venesection was never done. It is interesting to note the relative frequency of the first warning signals of toxemia: albuminuria, 94; elevated blood pressure, 69; edema, 9; convulsion 1; epigastric pain, 1.

SOME SIGNS AND SYMPTOMS

Further observations on the frequency of signs and symptoms that developed during the disease and were sufficiently severe to be noted showed the following ratio: albuminuria (with or without casts), 158; elevated blood pressure (150 or over), 136; edema, 91; headache, 58; nausea (with or without vomiting), 29; eye symptoms, 16; epigastric pain, 11.

This group of patients were observed on an average of 30.5 days from the time of the initial appearance of toxicosis until delivery. While conservative treatment was always tried, when possible, immediate delivery was done whenever the patient did not respond to her treatment. It was felt that conservatism ceased to be advisable if the patient was allowed to develop true eclampsia, or was becoming markedly worse. Dieckman⁵ expressed the opinion, generally held in this series of cases, when he stated that if there was no improvement in the toxemia, or that the condition

became worse after seven to ten days of treatment, the pregnancy should be terminated.

TYPE OF DELIVERY

The method of delivery was also based upon the theory that to follow conservative methods to their logical end would result in the loss of more mothers and more babies. The following table bears out this contention:

TABLE 1.—Types of Delivery			
Type of Delivery		Maternal Death	Fetal Death
Normal	57	2	8
Forceps	41		
Low, 16			2
Mid, 20			
High, 5			2
Breech	10		2
Version and extraction	5		2
Cesarean (35.12 per cent)	59	0	
Classical	52		2
Tubal ligation, 1			1
Hysterectomy, 4			1
Vaginal	3		3
Total deliveries	168	2	23
Twins	6	1.2%	13.2% corrected
Total number of babies	174		6.32%

In 168 deliveries of 174 babies, there were fifty-seven normal deliveries with two maternal deaths (the only maternal mortality in the entire series), and eight fetal deaths. Forceps were applied forty-one times, with four dead babies being born. Two fetal deaths followed the ten breech extractions, one craniotomy, and one of a set of twins. Following five version and extractions, there were two fetal mortalities.

MORTALITY

The first maternal death was that of a forty-year-old patient, who had had seven previous normal pregnancies with normal deliveries. Five days before labor she developed a mild preëclamptic toxemia. Two days following normal labor she was found to have a right pyelonephritis superimposed on a chronic nephritis, verified at autopsy. Death occurred eleven days postpartum. The baby was living and normal.

The second patient to die was thirty-six years of age, and in her second pregnancy. She had had a moderate preëclamptic toxemia for the last two weeks of her first pregnancy. She developed her first evidence of toxemia thirty hours before this confinement. Following hospitalization, labor was induced and she was delivered normally of a healthy, full-term child, though she had one convulsion during labor. A moderate postpartum hemorrhage was noted. Her condition became worse and death occurred only a few minutes after delivery.

Of the entire series there was a maternal mortality rate of 1.2 per cent, while the fetal mortality rate was 13.2 per cent with twenty-three deaths. By eliminating the prematures (before seven months), macerated fetuses, and the two babies,

already dead, on whom craniotomy was done, a corrected rate of 6.32 per cent is obtained.

CESAREAN SECTION

Cesarean section was done in fifty-nine cases—an incidence of 35.12 per cent—with no maternal and seven fetal deaths, all but one being premature. The classical operation accounted for fifty-two of these; four others were followed by hysterectomy, the so-called Porro section; three were delivered by vaginal hysterotomy.

Induction of labor was attempted with sixty-five patients, using one or more of these methods: castor oil and quinin, bagging, rupture of membranes, and some form of pituitrin. Four of these were not successful and eventually the patients were sectioned.

Because of the large percentage of cesarean sections, as compared with other reports, these are more completely analyzed:

Cesarean			Fetal Deaths
Indication: Toxemia (33)			
Fulminating		20	1
Only reason	12		
Disproportion	4		
Relative	3		
Flat pelvis	1		
Soft parts	4		1
Progressive toxemia		9	
Failure of induction	4		
Vaginal hysterectomy	2		2
Only cause given		4	
Indication: Obstetrical (26)			
Disproportion		11	
Funnel pelvis	5		
Relative	3		
Flat pelvis	2		
Justo minor	1		
Previous cesarean		4	
To sterilize		4	
Hysterectomy	3		
Tubal ligation	1		1
Abruptio placenta		3	
Classical	1		
Hysterectomy	1		1
Vaginal	1		
Heart disease		2	
Elderly primipara		2	
Total	59		7
Corrected			11.47%
			1.7%

The patients who had the cesarean operation can be grouped into two classes: (1) the cases in whom toxemia was the primary factor; (2) those who were operated for some other cause, but happened to have a relatively mild toxemia.

Of twenty-three cases of fulminating toxemia, twenty were sectioned. These were subdivided into twelve cases, who were operated because of the toxemia alone—one fetal death (prematurity); four with disproportion; four with long, uneffaced cervixes—one fetal death (prematurity). In the last eight cases it was felt that a prolonged labor would mean almost certain death of the baby, and would greatly add to the danger to the mother.

Four individuals were operated in whom no other cause than toxemia was stated in the records.

Nine patients showed definite signs of a progressing toxemia, which did not yield to conserva-

tive treatment. In four incidences induction of labor failed. Two of the nine had vaginal hysterotomies, with loss of both babies: one premature, and one craniotomy on a dead baby.

Thus, thirty-three cases were operated upon because of a severe toxemia, although about 58 per cent of this group had added indications.

OTHER THERAPEUTIC INDICATIONS

The indications for the remaining twenty-six individuals were primarily obstetrical. Disproportion accounted for eleven, with no deaths. Four patients had had previous section. Sterilization was either requested or urged four times: three of these were done by cesarean with hysterectomy, and one had tubal ligation following classical section at eight months, when the baby died two days postpartum. It is interesting to note that the indication for sterilization was the same in each case—toxemia in all preceding pregnancies. Hemorrhage, due to premature separation of the placenta, occurred three times: one classical section; one vaginal cesarean (loss of baby—prematurity); and one classical section followed by amputation of the fundus. In the last case the patient was forty-one, had had one previous baby, but lost this one due to prematurity. Two patients had heart disease sufficiently severe to be advised against vaginal delivery, and two were elderly primiparae.

No maternal deaths occurred among the fifty-nine patients who were delivered by cesarean section. Of sixty-one babies born, there were seven fetal deaths (11.47 per cent) with a corrected mortality rate of 1.7 per cent.

ECLAMPTIC GROUP

Of course, it is in the eclamptic group that the greatest danger lies. There were twenty patients who developed convulsions of varying severity—an incidence of 12 per cent of the 168 toxemias reported. Two of these were comatose when first seen. Classical cesarean section was resorted to in thirteen incidences; normal delivery in three; forceps in three; and vaginal section in one. One maternal death following normal delivery resulted in this group, a mortality rate of 5 per cent. The number of fetal deaths were four (20 per cent) with a corrected fatal mortality rate of 5 per cent.

TABLE 3.—Summary on Eclamptic Patients

	Babies Living	Born Dead
Total number of toxic patients.....168		
Pre-eclampsics		148
Eclampsics (12 per cent)..... 20		
Convulsions:		
Antepartum	6	3
Postpartum	5	0
Both	5	1
	16	4
Deliveries:		
Cesarean	13	
Normal	3	
Forceps	3	
Low	1	
Mid	2	
Vaginal cesarean	1	
Maternal deaths	1—5%	
Fetal deaths	4—20%	
Fetal deaths corrected.....	5%	

EVALUATION OF TREATMENT PROCEDURES

To try to evaluate any given form of treatment or any particular policy that may be followed in the care of the toxemias of pregnancy, is very difficult. We are dealing with a disease entity, the cause of which is obscure and the treatment symptomatic. A policy, such as was followed in this series of cases, would probably give rather disastrous results to the untrained person. Considerable judgment is necessary if one expects to have a relatively high incidence of operative deliveries with this type of patient and still keep the deaths at a minimum.

Conservative treatment and delivery certainly should be the care of choice for the general practitioner. For the specialist, who is adequately trained, a more radical point of view may be taken, to the advantage of both mother and child.

We know that about 50 per cent of women who have a toxicosis in one pregnancy will develop the same condition in subsequent pregnancies, with a resultant permanent damage to the cardio-vascular systems.^{6,3} The longer a woman is subjected to the effects of the toxins the more extensive will be the permanent damage and, consequently, the shorter her life expectancy. Herrick and Tillman⁶ conclusively show this to be true. Hence, the necessity for immediate termination of the fulminating cases and those patients who become worse under conservative treatment.

COMMENT

The following discussion is not based on an extensive scientific study, but represents an opinion founded on clinical observations and deductions made from our present knowledge of the toxemias. No attempt will be made to elaborate upon the many theories suggested to date.

It is generally conceded now that there is a definite association between the nausea and vomiting of early pregnancy and the toxemias of late pregnancy. A number of authorities agree that this disease entity is due to some toxin or toxins of unknown origin,^{8,8,2} which have a predilection for different organs in different individuals leading to classifications of toxemias on a basis of symptoms and pathology.⁹ McIlroy⁴ states that "different symptoms may preponderate at various stages of pregnancy, but the ultimate cause is the same in most cases." This association is shown in the series just reviewed. About 50 per cent of all pregnant women have varying degrees of nausea in the first trimester,³ but we find that 71 per cent of the above group record this complaint. Further analysis of the data shows that nausea occurred early in pregnancy in 76 per cent of the severe toxemias, and this ratio is raised to 81 per cent of the patients who later developed convulsions. Seemingly, the more severe the subsequent toxemia the more frequent will have been early nausea.

We are taught that adequate prenatal care will cut down the frequency and severity of toxemia. No doubt this is true, but how can one account for an incidence of eclampsia of one to two hundred and fifty deliveries in this group, which cer-

tainly have had better prenatal care than in the country as a whole where the incidence is one to six hundred deliveries?

RÔLE OF TOXINS AND ALLERGENS

It is felt by the essayist that the etiology of the toxicoses of pregnancy in many cases may be based upon the increased sensitization of the patient to the presence or formation of toxins or allergens foreign to the host. These in some way may react to or with a certain hormone or hormones (possibly gonadotropic) to form the symptom-complex known as the toxemias of pregnancy.

As examples, the following may be cited. Any infectious process, such as teeth, tonsils, appendix, endometritis, etc., can form a toxin which is developed within the patient. Furthermore, we know that if this focus of infection can be removed, a certain number of toxic pregnant women will become symptom-free of their toxemia.

Allergens also may be the exciting cause. A thirty-year-old primipara, who complained of frequent headaches and skin eruptions before pregnancy, developed a severe nausea and vomiting with upper abdominal pain. Hospitalization on two occasions only gave temporary relief. An acute pyelitis appeared, was helped by kidney lavage, but underwent spontaneous cure when sufficient acidosis occurred. After removal of milk and eggs from her diet, her nausea and vomiting immediately cleared up, with no recurrence unless she "cheated" on her diet.

The relationship of the toxic element with the hormonal is based upon three proved observations. First, is the pregnancy test of Aschheim and Zondek, in which large amounts of anterior pituitary substance are produced shortly after conception. In the hydatidiform mole, a greater quantity of the hormonal substance is given off. Can there be any association between this and the fact that toxemia is more frequent in the presence of a mole? Secondly, Knepper¹¹ and Rössle¹² have reported typical eclamptogenic lesions of liver and kidney in experimental animals by the injection of posterior pituitary extract and horse serum. Lastly, Evans⁷ has shown that "gonadotropic hormone is abundant in the urine by the first missed period and reaches a maximum by the fourth to fifth month of pregnancy. In the toxemias of pregnancy, extremely high amounts have been encountered in the last third of gestation. The hormone disappears very rapidly following termination of pregnancy." When one interrupts pregnancy, one accomplishes two things: almost immediate cessation of toxemia and marked reduction in the concentration of pregnancy hormones.

OTHER THEORIES CONCERNING THE TOXICOSIS

It does not seem tenable that the products of conception, as such, could in any way form a toxic substance which would be detrimental to the host. This theory has been suggested several times and more recently by some German writers. Egorov¹³ maintains that the ovum is normal, and there is no specific toxin in the toxicoses of pregnancy, but that it is an allergic reaction because the

normal immunity of the mother toward the growing ovum is underdeveloped or absent. This especially is true in patients prone to metabolic disturbances. May not the "neurotic" patient, who more frequently develops toxemias, also be prone to more severe metabolic disturbances?

On the other hand, Jegerov¹⁴ states that the toxicosis is due to a sensitization to the waste products of fetal metabolism. If there is a reaction to the products of conception or their waste products, why is the human being the only animal that manifests any evidence of toxemias? Why did Bergsma,³ during nine years of practice in Java, never see a case of eclampsia? Why was there 50 per cent less eclampsia in Germany during the war than in peace times?

It may be possible that primiparae are more liable to toxemia than multiparae because they are experiencing their first major hormonal-allergic test. If so, may they not develop a desensitization to these allergens which is more or less permanent and so prevent toxemia from appearing later in the pregnancy or during subsequent pregnancies? The multiparous patient, with an allergic diathesis, would then be the one who has repeated toxicoses.

Irving¹⁵ has recently published an article giving the pathology to be found in the preëclamptic and the eclamptic patient. The conclusion reached was that the essential lesion is an arteriolar spasm affecting especially the peripheral arteries of the brain, kidneys, and liver, although all arterioles were similarly constricted. He suggests that this spasm may be due either to stimulation of the vasomotor center or direct action on the vessels. The train of signs and symptoms found in the toxemic patient can be accounted for on this basis. Other authorities¹⁰⁻¹⁵ have suggested that the liver and kidney lesions were of vascular origin due to the effects of toxins.

Bartholomew and Krake¹⁷ reported that "hypercholesteremia due to hyperpituitary or hypothyroid activity was the fundamental basis for the toxemias of pregnancy," and that this is "further increased by a diet high in cholesterol-containing foods." What of the hypothyroid Eskimo, who lives on fish, meat, and blubber?

COMMENT

Treatment offers another source of conjecture because of diametrically opposed ideas. One reads of good results obtained from forcing fluids and limiting them, of satisfactory reports when proteins are given or restricted. The controversy of conservative and radical treatment continues to rage. In the end one is left to abide by his own judgment and experience.

Unlike syphilis or tuberculosis, which can give a multiplicity of pathologic and clinical changes due to one agent, we will probably find that in the toxemias of pregnancy we are not dealing with one specific factor, but an increased activation of toxins and allergens in association with hormonal influences.

Perhaps it is a pessimistic point of view, but as long as civilization makes its demands upon us to live a strained abnormal life and requires that we indulge in perverted diets, etc., pregnant women are going to continue to have toxicoses and eclampsia. At best, we can only reduce the incidence of each and prevent some deaths by prophylactic measures and quick action if our treatment proves ineffectual.

IN CONCLUSION

1. In 4,979 consecutive deliveries, 168 women (3.35 per cent) developed toxemia of late pregnancy. Twenty (12 per cent) of the toxic patients developed eclampsia.

2. There were two maternal deaths (1.2 per cent) and twenty-three fetal deaths (13.2 per cent, corrected mortality rate of 6.32 per cent).

3. Cesarean section was resorted to in fifty-nine cases, with no maternal deaths and seven fetal deaths (11.47 per cent, corrected mortality rate of 1.7 per cent).

4. Maternal and fetal mortality can be cut to a minimum if the pregnancy is terminated as soon as it is found the patient is becoming worse or not improving under conservative treatment.

5. In the case of fulminating and eclamptic toxemia, cesarean section is the delivery of choice, provided that rapid vaginal delivery cannot be done.

6. To prolong conservative treatment without definite improvement means increased damage to the cardio-vasculo-renal systems, with a resultant shorter life expectancy.

7. There is apparently a definite relationship between the early and late toxemias of pregnancy.

8. This relationship may be based upon an increased sensitization of the pregnant patient to toxins or allergens which in some way react to the greater concentration of pregnancy hormones.*

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DISCUSSION

H. A. STEPHENSON, M. D. (490 Post Street, San Francisco).—This analysis of late pregnancy toxemias is a most interesting one. It shows the incidence, diagnosis, and treatment of toxemias as interpreted by a well-trained obstetrician having a large practice and employing the facilities of modern hospitals in the care of his patients.

Much stress has been laid on the importance and value of prenatal care. It should result in discovering the presence of toxemia in its incipency. The institution of prompt treatment at this stage will frequently avoid the more serious complications which come from the condition if allowed to continue too long. In this particular series the prenatal care averaged about five months per patient, which is considered adequate. The author brings out an interesting and rather surprising fact when he shows that about one-half of the multiparae had suffered from toxemia in previous pregnancies. This high figure makes necessary more careful observation and supervision of such patients. Personally, I have found that increased blood pressure is the earliest and most constant finding in toxemia. Doctor Campbell finds that albuminuria comes first.

There can be little criticism as to his procedure regarding treatment. Conservative or medical treatment which he outlines in some detail should be tried first. Should such treatment not result in satisfactory improvement, some procedure to bring about delivery is then indicated. The fact that there were twenty cases with convulsions leads me to believe that medical treatment may have been too long employed, and more prompt delivery might have forestalled some of these convulsions. In my own experience convulsions do not occur nearly as often as here reported (12 per cent). Cesarean section was employed in 35 per cent of these cases as the method of choice in terminating the pregnancy. Even in the patients with convulsions it was used in thirteen of the twenty cases. This would be severely criticized by many authors, and there are many articles in the literature which show that the mortality rate in patients suffering from toxemia with convulsions is greatly increased when cesarean section is done. The results obtained in this series, however, speak eloquently, as there were no deaths in the fifty-nine cesarean cases. The fetal mortality rate is in keeping with that which has been reported from other clinics.

The author is to be congratulated upon the excellent results obtained in this series. After all, this is the test by which work is judged.

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L. GRANT BALDWIN, M. D. (65 North Madison Avenue, Pasadena).—This paper is of interest to all practicing obstetricians, as it discusses a subject we all fear and respect. It differs from most similar reports inasmuch as it deals with a large group of private patients cared for under more or less ideal conditions rather than, as usually is the case, with a group of cases from some large hospital service. It quotes figures we can compare with our own experiences, and does not leave the usual implication that we are reading something somewhat foreign and of chief interest to the larger or teaching institutions. One's first reaction, on reading that 3.35 per cent of a series of 4,979 pregnancies developed sign and symptoms of toxemia, is one of astonishment that adequate prenatal care had not produced a lower incidence; however, more mature thought impresses one with the fact that, inasmuch as toxemias are still of such an unknown and disputed eti-

ology, this incidence is in reality quite low. However, it again proves our inadequacy to prevent these much-feared conditions, failure to prevent them even in the hands of most competent individuals. All of which leads to the conclusion that our methods of prevention are not improving materially, but that our hopes, for the present at least, must be placed in an early apprehension of toxicity, together with prompt and adequate treatment.

Both the believers in the strict conservative method of treatment, and also those who have advocated radicalism, have given ground until today; the majority favor a program essentially similar to that outlined by Doctor Campbell. His statement regarding the opposed theories of treatment, such as increased versus decreased fluid intake, exemplifies the fact that a strictly routine treatment is not advisable, and that each case must be treated on its merits. This rather supports his interesting discussion regarding the possible etiologic values of toxins, allergens, or hormones. This conception is new to most of us, and one difficult of proof; however, certainly not improbable. The massive amount of study now in progress, we hope, will lead to a more advanced understanding of the specific etiology of these conditions; then, and only then, can one hope to decrease the frequency of toxemias. Until then adequate prenatal care, plus prompt and systematic treatment of threatened toxemias with operative interference when conservatism fails, seem our only possible course.

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JOHN W. SHERRICK, M. D. (350 Twenty-Ninth Street, Oakland).—It is difficult to add much of importance to this paper, as Doctor Campbell has covered the subject well and carefully. This report reflects my own and Doctor Loomis' reaction to the whole subject of toxemia of pregnancy. We feel justly proud of these results, namely, a 1.2 per cent maternal mortality and a 6.3 per cent (corrected) fetal mortality, especially when one compares them with the high mortality rate (20 per cent maternal and 36 to 42 per cent fetal), as reported in the literature.

There are several points of special interest in this paper, such as, first, the high incidence of association between early toxemia of pregnancy with late toxemias; second, the tendency for recurrence of toxemia in subsequent pregnancies (50 per cent), thus indicating or favoring permanent kidney and liver damage; third, the persistent failure to arrive at an etiologic explanation of this picture.

Attempts at explanation of an etiologic factor still do not seem to have proof for the various theories. Doctor Campbell's suggestion of a sensitization reaction is ingenious and perhaps much more plausible than most of the others; but it is not proved, and I am afraid we must search further and delve more deeply for the answer. Certainly, it would seem to be a most complex phenomenon whatever is the explanation.

We have always felt that if toxemia patients do not definitely improve under intensive intelligent conservative treatment, their condition is progressing with increasing danger to the mother and her baby and all that this imposes in immediate and remote effects. In such circumstances we have favored relieving the burden by emptying the uterus by whatever method seems safest for both members. Our incidence of 35 per cent of cesarean section may seem high, but the excellent results of no maternal mortality and of only one fetal death—a percentage of 1.7 per cent after elimination of those babies who were too premature to have a chance of survival—more than justify the procedure. We have always felt that this method, instituted relatively early, inflicts the minimum of trauma and stress upon the mother and her babe, and offers the quickest and safest means of relieving the toxic burden imposed upon both, thus preventing avoidable, inexcusable, and dangerous trauma to the baby and to the mother's cardiorenal-vascular system. I think the results reported here will stand comparison with any series treated by the so-called conservative measures. The secret of such success depends on having had these patients under constant prenatal supervision and control; in having available every facility for carrying out adequate care, and in knowing when to interfere. Under such circumstances and with trained obstetricians, so-called radicalism becomes intelligent conservatism.

SILICOSIS*

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THE most ancient of working men's maladies becomes, rather suddenly, an industrial octopus—firm, far-reaching, and formidable. The ancient "disease of stone cutters," recognized by Hippocrates, recorded by Agricola ("De Re Metallica," 1556), Paracelsus (1567), and De Ramezzini (1671 and 1705), now appears as the most important industrial disease problem in America today.

INCIDENCE

Over a half-million persons are exposed to silicosis in this country. While tuberculosis has decreased over half, silicosis has increased over thirteen times. The activity of the legal profession, plus the shameful "expert" testimony of certain of our colleagues, is in a large way responsible for the recent claims and litigation now being considered, particularly in California, Ohio, New York, and Illinois.

In the latter state, in three years (1933 to 1936), suits have been pending, the paper value of which is \$100,000,000. One company alone is defending claims of \$10,000,000, all filed in this three-year period. In our own State the claims against just one company (California State Compensation Insurance Fund) have been so numerous that special legal counsel has been necessary for their exclusive handling.

This is a paper on an industrial medicine topic; therefore a clinical exposition of this disease entity is not forthcoming in any detail, but may be obtained in a late publication.¹ Suffice it to say here that the etiology is inhaled free silica (SiO_2), usually microscopic. As the tools and technique of industry have become more accurate, powerful and advanced, so have the dust particles become finer and more pure. The important etiologic factor is that the lung injury is not traumatic or mechanical, but a chemical assault.

SILICOSIS DIVIDED INTO THREE STAGES

Clinically, the disease is usually divided into three stages, variously named, but universally accepted in this country as well as in England, Canada, and South Africa. The cardinal symptom of silicosis is dyspnea; the cardinal sign is decreased chest expansion. The first stage presents a pretty healthy picture with usually only two findings to create suspicion—a dry cough and a limited chest expansion. The second stage reveals exacerbation of the first stage plus chest pain, expectoration and hemoptysis, dyspnea, and impaired working ability. In the final stage the dyspnea is marked and distressing; cough is harsher and more constant; there is usually copious expecto-

ration, weight loss, and all the signs of decreased pulmonary function.

Nationality plays no part, as no race is exempt.

Age in itself, also, seems to play no part. The majority of the patients are in the latter half of their third decade—probably because they have worked about long enough to produce symptoms.

Any constitutional defect speeds up the progress of the disease, particularly lues, tuberculosis, and other respiratory-tract infections.

The average period of development of silicosis in those exposed is ten years; yet it may be two or twenty-five.

The severity depends on three factors:

1. The number of dust particles per cubic foot.
2. The amount of silica in the dust.
3. The frequency and duration of exposure.

TREATMENT

So much for the clinical picture. The treatment is the treatment of tuberculosis—rest and constitutional measures, to increase the general health and resistance to other disease. Of course, withdrawal from contact with dust is necessary. The latter, however, has often taken place before the diagnosis becomes apparent—from days to years. The prognosis is good in the first stage, fair in the second, and poor in the third.

RELATIONSHIP OF TUBERCULOSIS TO SILICOSIS

Now a very controversial question enters the picture. What is the relationship of tuberculosis to silicosis? The answer is the opinion of the one who replies. First, let us acquaint ourselves with a few known facts:

1. Seventy-five per cent of silicosis sufferers die of tuberculosis.
2. The tuberculosis factor may appear in any stage of the disease.
3. A quiescent tuberculosis may be reactivated by exposure to silica.
4. The more extensive the silicosis when tuberculosis first appears, the more rapid the progress of the tuberculosis and the death of the afflicted.

Those are facts. Now, answering the initial question, it is my personal opinion that every silicosis victim is or was an active, quiescent or potential tubercular, or silicosis would not gain the headway it does; nor would tuberculosis kill 75 per cent of silicosis victims, as it does.

IMPORTANT FACTORS IN DIAGNOSIS

So far, two very important factors in diagnosis have not been discussed here. The first is of tremendous importance, being the necessity of a long, accurate, detailed industrial history of the patient. Unfortunately, we often have to employ private investigators over a long period of time to get such a history, as many of the claimants seem to have a memory strangely at fault when it comes to answering questions. That history should go back to the first working days of the individual. The last, and yet often the first all-important factor in diagnosis, is the x-ray examination.

* Read before the Industrial Medicine and Surgery Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

¹ Silicosis Pneumoconiosis: Clinical and Industrial Aspects, Northwestern Medicine, Vol. 35, No. 5, May, 1936.

I believe that most experienced roentgenologists feel that the roentgen picture of a man's chest reveals a fair index of a man's "respiratory past." Therefore, only the trained, experienced eye should formulate an opinion regarding silicosis from a roentgenogram. There is evidence of many respiratory tract experiences in a chest picture. Yet I realize very often our only positive evidence of silicosis is in a film. I am merely pleading for interpretation by a qualified roentgenologist.

The silicotic lung, uncomplicated with tuberculosis, for instance, in the first and second stages shows a distinct, individual x-ray appearance. The pathology is one of increased fibrosis, is always bilateral and never limits itself to a particular isolated area in the lung. It appears as a beady or reticulated fibrosis and is found in the hilar areas, extending peripherally like the branches of a tree. The apices and bases are the last to be affected, if at all.

INDUSTRIAL AND LEGAL ASPECTS OF SILICOSIS

Now a few words about the industrial aspects. Suits on file in this country now aggregate, on paper, about \$500,000,000. Reputable and disreputable members of the legal and medical professions are largely responsible for this deplorable situation. A review of most of their hearings and trials leave an honest practitioner of medicine or an honest lawyer sorely disgusted and distressed about so-called "expert testimony." The vast majority of these claims are presented in courts; juries are often ignorant, biased, generous, and bewildered. They often do not know whom to believe, and give the benefit of the doubt to the ailing (?) claimant.

Also the statute of limitations for filing claims or suits in this State now has an indefinite time limit. As a result of the Marsh case *et al.*, the Supreme Court considered that a man is not suffering from an occupational disease until he has definite belief or information that his symptoms are related to the work he was doing—even if it were years before.

SOLUTION OF THE PROBLEM

What is the solution to two problems—the prevention of the disease, and the honest disposition of half a billion dollars' worth of claims? The solution in prevention holds many immediately feasible possibilities. I mention the following measures which appear to me to be practical:

1. Compensation laws that will allow and recognize the physical and radiologic examination of men applying for employment in dusty trades.

2. Periodic physical and roentgen examination of those at work in these trades. This would allow rejection of the unfit and a warning to those with early evidence of silicosis.

3. Preventive measures at the site of the employment, such as:

- (a) Analysis of dust particles per cubic foot of air.
- (b) Increased ventilation, *i. e.*, air velocity.
- (c) Wet drilling, grinding, etc.

- (d) Control of dust at its point of generation.
- (e) Determination of what is a harmful dust.
- (f) Tuberculous workers prohibited from dusty or underground employment.

(g) Standardization of records, examinations, and inspections.

(h) The ascertainment of dust hazard for each trace, and the threshold limits of safety.

(i) The use of an efficient respirator.

4. The creation of a medical board of appeal who would determine the justice and propriety of a claim leading to the law courts.

5. Compensation award should be made only on the *occupational* disability of the claimant.

6. First-aid safety measures by the employer:

(a) Filtering plants for water.

(b) Bath houses.

(c) First-aid stations.

(d) Easily obtained and low-cost medical care.

DISPOSITION OF SILICOSIS CASES NOW PENDING

Finally, we come to the problem of the present—the disposition of the hundreds of cases now pending, a few legitimate, but the vast majority undeserving and unwarranted.

1. The answer is immediate and close coöperation between the legal profession, the doctor and the employer. The courts should only allow an expert witness of the highest caliber to testify regarding x-ray interpretation. The local or national Roentgen Ray Society should either approve of the expert, review the testimony of so-called experts, or both.

2. Employers *must* spend money to analyze dust hazards, both to eliminate them for the future, and to ascertain whether any hazard has really existed heretofore.

3. Modern legislation by states covering all industrial diseases, with special reference to those peculiar to the various trades and occupations.

4. Eliminate the quack and charlatan in medicine and in law. That job is the duty of the ethical medical and legal societies. A "visiting court committee" from the county or state medical society should sit in on cases where expert medical testimony is given. The Bar Association should investigate and properly chastise the ambulance-chasing lawyers, some of whom have handled dozens of cases, employed the same doctor in as many as seventeen suits, combed the wards of county and other hospitals for patients who worked in industries, etc.

IN CONCLUSION

To me, however, the most important move for everyone's benefit is the creation of a medical board of review, that board to decide whether or not a case is compensable at all; then a lay commission to decide to what degree, "occupationally speaking," that claimant is disabled. Those two procedures should result in justice to the claimant, the employer, and the insurer. They would also stop suits in our courts with their evils of cost, unexpert testimony, jury verdicts, delays, and grossly unfair awards.

California was a leader in compensation laws to protect the worker. The State, therefore, may well be one of the first to protect industry and the employer!

384 Post Street.

DISCUSSION

HOWARD E. RUGGLES, M.D. (384 Post Street, San Francisco).—From the x-ray standpoint, an ideal arrangement would be to secure at least one film of every individual before his employment in a dusty occupation. A man with evidence of an old or latent tuberculosis should, of course, be excluded from any such occupation. Practically, this ideal is unattainable, at least at the present time, but employers and insurance companies would find that a roentgenological survey of employees subject to dust hazard, once in three to five years, would more than repay the expense incurred.

As in so many other conditions, the earliest stages of silicosis give no characteristic roentgen picture. The first recognizable evidence of the disease is an enlargement of the hilar shadows and a thickening of the bronchial markings, particularly those toward the bases of the lungs and posteriorly. There next appears a variable amount of pleural thickening, followed by the development of the characteristic silicotic nodules in both lung fields. These are rounded areas of increased density, 3 to 5 millimeters in diameter, with hazy margins, usually scattered fairly symmetrically in the lung fields, particularly in the posterior halves. With continued exposure, these nodules enlarge and coalesce, as the result of a progressive fibrosis. The process ends in a terminal tuberculosis or, less commonly, cardiac failure, due to interference with the lung circulation. In many cases where films of the individual are not available until the later stages of the disease, it is difficult to decide how much of the fibrosis present is due to the underlying silicosis, and how much to the secondary tuberculosis. Earlier films in such cases would be invaluable.

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SIDNEY J. SHIPMAN, M.D. (490 Post Street, San Francisco).—Doctor Behneman has written a timely and comprehensive analysis of the silicosis problem. Fortunately, the importance of this disease is now generally recognized. The means of prevention are fairly well understood, and the outlook, therefore, much brighter than it has been at any time in the past. The fact that silicosis is *per se* one of the purely industrial diseases and, therefore, involves a pecuniary factor of great importance, has no doubt greatly accelerated its study and prevention.

There are one or two minor points in Doctor Behneman's paper which, while not highly important, might be open to argument; whether, for example, the etiology of the pulmonary injury is not traumatic or mechanical, but a chemical assault, might be questioned. There are still those who believe that the mechanical factor is not unimportant.

In discussing the importance of tuberculosis as a complicating factor of silicosis, Doctor Behneman does well to point out that most silicosis victims sooner or later develop tuberculosis. The importance of this observation emphasizes the necessity for adequate antituberculosis measures in communities where the silicosis hazard is high, as in the Mother Lode district of California. The California Tuberculosis Association has recognized this field as a new arena for concentrated endeavor, and it is to be hoped that the measures now in use for the prevention of tuberculous infection and disease will be applied more intensively in the future in these communities.

The other methods of prevention, in the occupational sense, have been adequately described by Doctor Behneman. The various measures for eliminating dangerous concentrations of dust particles are, of course, highly important, although in this connection it is somewhat questionable whether respirators really furnish much protection, or whether they merely give a false sense of security and thus lead to abuses. As far as periodic examinations are concerned, there seems to be a perfectly understandable but, from the medical standpoint, unjustifiable opposition on the part of labor unions. These unions must be won over to the medical viewpoint by proper

education, when I feel sure their enthusiastic coöperation can be enlisted.

As Pierson has repeatedly pointed out, what we need in California is an impartial silicosis commission or silicosis institute, probably connected with one of the large universities, for the purpose of studying the problem as it affects California, and furnishing impartial advice and testimony wherever needed.

THE SO-CALLED "STRADDLE" INJURY: ITS MANAGEMENT*†

By EDWARD W. BEACH, M.D.
Sacramento

DISCUSSION by Thomas E. Gibson, M.D., San Francisco; Jay J. Crane, M.D., Los Angeles.

IT was Plato who said, "All science is but remembrance," and we seek herein remembrance and recapitulation of certain basic facts with regard to this type of injury rather than the promulgation of any novelty or innovation.

REASONS FOR THIS ARTICLE

The reasons for this article are several, all of which seem important to us.

1. These straddle injuries are fairly common in industrial practice. They should, therefore, interest the surgeon to whom the unfortunate man first applies; the urologist who may be called because the urethra is frequently involved; and last, but not least, the insurance carriers, because they pay the bills.

2. There is little to be found in standard textbooks concerning these straddle injuries, and this little is handled in rather a perfunctory and empirical manner. Usually no attempt is made to rationalize their treatment. Elaborate embroidery patterns for urethral anastomosis are artistically demonstrated and often advised under these circumstances, which makes one with experience conclude that many of these cases were purely hypothetical, and treated in the "mind's eye" rather than at the bedside.

3. It has been our observation that many otherwise most excellent surgeons view this type of injury askance and with a commingling of awe and horror somewhat akin to Magellan's feelings when he first beheld the Southern Cross in navigation of the equatorial zone. This may be a tribute to enthusiastic urologic propaganda, but at any rate the male urethral perineum is still hallowed ground for most general surgeons in point of fact, and occupies with them about the same status today as in the era of the Collots. Taken all in all, perhaps no injury is viewed by them with more consternation, foreboding, perplexity and uncertainty than one which occurs in the urethral perineum in the male.

* Read before the Urology Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

† An apology is due the strict grammarian for our legerdemain with the word "straddle." To assume this license in a scientific article is, doubtless, reprehensible. However, for the surgical mind the erstwhile adjective "straddle" has a deeper and different connotation. It represents a concise, graphic and descriptive, if somewhat loose and ungrammatical, method of grouping a common industrial accident. Moreover, frequent technical application in this connection has liberalized and almost standardized this grammatical error in this way among the profession.

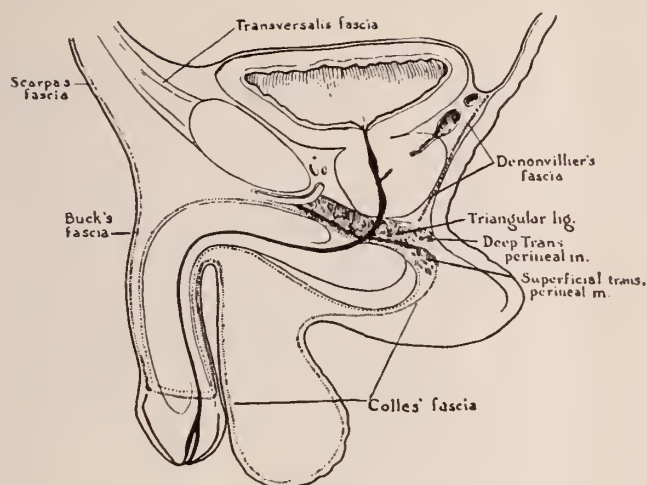


Fig. 1

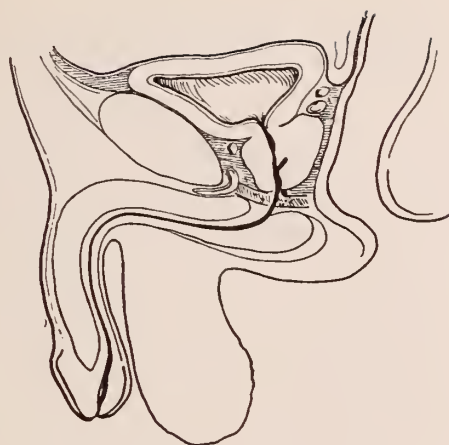


Fig. 2

Fig. 1.—Fasciae of importance in urinary extravasation (after Wesson). Colles's fascia is concerned in nearly all extravasations and its abdominal continuation. Scarpa's fascia is less frequently involved. Intrapelvic extravasations are least commonly observed.

Fig. 2.—When extravasation originates on the pelvic side of the triangular ligament, retroprostatic, perirectal and ischio-rectal infiltrations are most commonly observed, although perivesical involvement may occur.

4. We, therefore, seek to review and clarify this subject in a practical way, hoping to dispel some of this mysticism anent the perineum and injuries therein.

5. Finally, it has been our good fortune to have treated a number of these straddle cases. We have adduced, from their care at the bedside, certain principles which have helped us. We will attempt to set forth these principles, with a hope that they may help others also.

ANATOMIC FACTORS

Site of Injuries.

From the standpoint of mechanics, when an individual falls astride a flat, unyielding surface such as a timber, the soft tissues and urethra of the perineum are commonly pinched between the timber below and the undersurface of the pubic arch, or the transverse ligament above.

In such an accident, with the force applied more or less at right angles to the perineal surface, the bulbar urethra is seldom injured, although it is nearest the surface, most exposed in position and relatively extensive in spread. From an anatomical standpoint (Drawing A), it is seen that the urethral lumen traverses the bulbar expansion in such a way that approximately two-thirds of the surrounding erectile tissue is beneath the urethra itself, or between the latter and the perineum. This tissue acts as a cushion, therefore, to the urethra. Moreover, the bulbocavernosus muscle likewise furnishes additional protection to the bulb itself.

Thus, when the perineum receives a sharp blow or is subjected to a crushing force (as in a fall astride a broad, immobile surface), these anatomical bulwarks usually render the bulbar urethra immune. Instead, by virtue of that dense fascial sheath, the superficial layer of the triangular ligament, this force is transmitted to and brought to bear upon the weaker and unfortified abutting membranous structure, *i. e.*, the terminal or distal

membranous urethra. Furthermore, this terminal membranous urethra invites injury because of its unusually thin-walled structure and its relatively fixed position in close proximity to the pubis and ischium. A point of great practical importance in this connection is that since most strictures are located in or near the bulb, this natural thinness of the membranous structure is enormously enhanced by the dilatation behind such an impediment and its vulnerability to trauma proportionately increased. For these reasons, therefore, partial rupture often accrues in the distal membranous urethra in the ordinary type of straddle accident, and in our experience the floor is most often involved, leaving the roof intact.

There is now a second and distinctly different type of injury which primarily implicates the bulb. Force of a tangential nature is brought to bear upon this structure either from the side or more often from the rear. Because of this violence the bulb is dislocated or torn from its attachments to the triangular ligament and thrust forward often over the anterior surface of the pubis, which ordinarily assumes an angle of about 30 degrees with the horizontal. In this mechanism avulsion or complete rupture of the urethra transpires again in this distal membranous structure or in the immediate vicinity.

Extravasation Possibilities.

The practical surgeon, with regard to extravasation, considers the urethral perineum like Caesar's Gaul—to be divided into three parts, to wit: (1) territory within the superficial perineal interspace; (2) territory between the inferior and superior layers of the triangular ligament or urogenital diaphragm; and (3) territory above or proximal to the superior layer of the triangular ligament. For completeness, it is also necessary to take cognizance of a fourth territory concerned more often with rupture of the pendulous urethra, namely, extravasation between the layers of Buck's fascia. In certain instances when urethral rupture

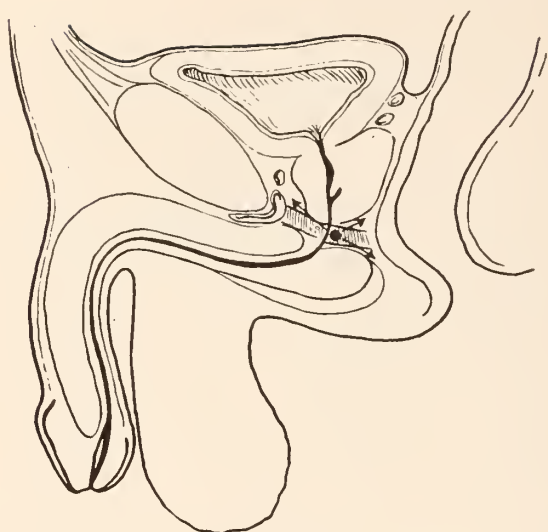


Fig. 3

Fig. 3.—If extravasation originates within the triangular ligament, extension occurs in either direction, most often externally.

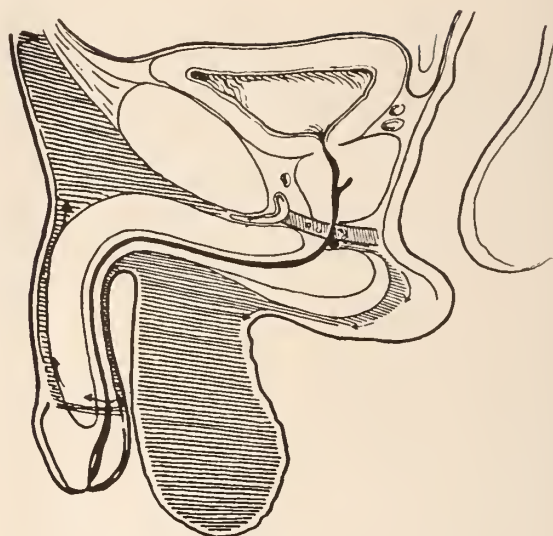


Fig. 4

Fig. 4.—Spread of extravasation when primary focal lesion is anterior to the triangular ligament. A course bounded by Colles's and Scarpa's fasciae is pursued.

occurs at the root of the penis within the sheath of the corpus cavernosum, the advancing extravasation is confined to very narrow limits by a special fascia. This fascia, as described by Buck, is a membranous sheath completely encompassing the corpus cavernosum, and taking its origin above and behind from the suspensory ligament and below from the perineal fascia. It invests the corpus cavernosum closely and is bound to the corpus spongiosum above by two reflections, one of which passes above the latter and the other beneath.

The superficial perineal interspace holds the most interest for the straddle surgeon. It will be recalled that the vulnerable portion of the membranous urethra (the distal portion) lies in this interspace. Extravasation here cannot go upward because of the dense inferior diaphragmatic fascia, nor can it go backward into the ischiorectal region because of the deep layer of the superficial fascia (Colles's), which fuses with the former at the base. Moreover, the extravasation cannot spread into the thighs, because both the inferior ligament and Colles's fascia attach laterally to the pubo-ischiatic rami. Hence, the tumefaction confined beneath Colles's fascia tends to advance forward over the perineoscrotal angle into the scrotum, and later up over the pubes.

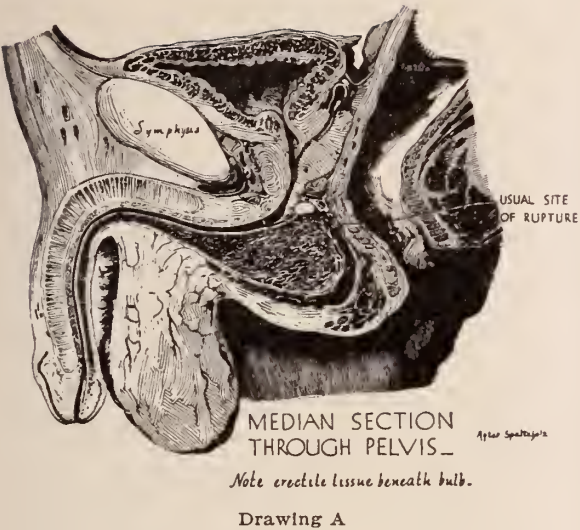
That portion of the membranous urethra between the inferior and superior layers of the triangular ligament is sometimes involved in these straddle injuries, and particularly by puncture wounds. Should accumulation take place here it remains confined for a time, and then may slough through either ligament, *i. e.*, down into the superficial perineal interspace or up into the territory above the deep layer of the triangular ligament. However, any extravasation proximal to the superficial layer of the triangular ligament may seep backward into the ischiorectal region and buttocks or into the thighs.

The territory above the superior layer of the triangular ligament is seldom concerned in these accidents save by puncture wounds. In these cases the extravasation is held forward by Denonvillier's fascia and often, by pushing up the peritoneum from the bladder, passes into the cave of Retzius. In two puncture cases involving the deep urethra (these may have involved the proximal membranous structure with rupture of the deep triangular ligament), in this series we found perhaps a quart of blood and urine in this area while performing cystotomy. On the other hand, the extravasation may at times extend retroperitoneally up to the diaphragm.

CLINICAL MATERIAL

This article is based on sixteen of these straddle injuries seen by the author in the last twelve years of practice. Many were seen in consultation at small hospitals in northern California. Several were seen at the Jones Memorial Hospital in Grass Valley, among gold miners, through the courtesy of Doctors Carl Power Jones and Walker Reed. For others the author is beholden to his surgical brethren in the peripheral area and to the insurance carriers. It is well to remember in this connection that the urologist is consulted only in the complicated and more difficult cases.

The oldest man in this series was fifty-six and the youngest, fourteen. Most were husky workers in the prime of life. Nearly every sort of object was straddled, *viz.*, a bench support, a stepladder, a fence, a curb, a stump, a rock, a steel rail, but most often a piece of timber used as a brace in the mines. The mechanics of the accident remained virtually the same throughout. Variants involved (*a*) the distance fallen, and (*b*) the contacting surface. (*a*) The distance fallen was difficult to estimate in many cases. The shortest distance was approximately two feet, and the longest



almost twenty feet. The distance dropped offered no index as to the urethral lesion except in the broadest possible sense. In two stricture cases the fall was trivial, while in the longest drop little urethral damage accrued. (b) Contact was most often with broad or blunt surfaces—therefore, the twelve closed cases in this series as opposed to the four puncture or open cases. None of the latter involved the rectum.

ANALYSIS OF THE CLINICAL MATERIAL

Under this caption subheadings have been arranged for convenience and simplicity, and whenever possible appropriate deductions made.

1. Urethral Injury.

These injuries comprised three general groups: (a) partial rupture on the floor of the distal membranous structure of which there were eight cases; (b) complete urethral rupture often by tearing loose the bulb from its fixed position of which there were four cases; and (c) four puncture wounds, of which one involved the membranous urethra, one the bulb directly, and two either the proximal membranous urethra or the distal pros-

tatic urethra. The exact nature of the urethral lesion was difficult to estimate; but when catheterization was possible it was assumed that the rupture was incomplete.

2. Preëxisting Urethral Strictures.

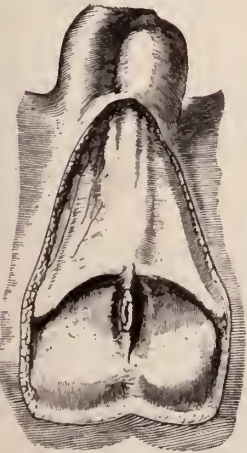
Incidentally, two men in this series had a penile hypospadias. Seven of these sixteen cases presented evidence of stricture. The high incidence of the latter finds explanation both in the great prevalence of this fibrous legacy, and as to its pertinent application from an anatomical standpoint. Moreover, most strictures are ineffectually and inadequately treated because of the sufferer's attitude, which may be crystallized thus: "The devil was sick, the devil a monk would be; the devil was well, the devil a monk was he." Most of these individuals quickly acquire this disposition to avoid treatment, from which nothing can dislodge them except another attack of acute urinary retention.

3. Urinary Retention.

Only five of these patients were able to void spontaneously after the accident. Three refused subsequent treatment after catheterization, and two returned a few days later with urinary extravasation. Moreover, the author has seen three other patients who presented the clinical picture of urethral rupture, but refused examination because they were able to void without difficulty, and one later developed extravasation. It is, therefore, our conviction that when the urethra is injured and there is broken continuity, the act of voiding by reason of the vis a tergo forces the urine out into the tissues and favors extravasation.

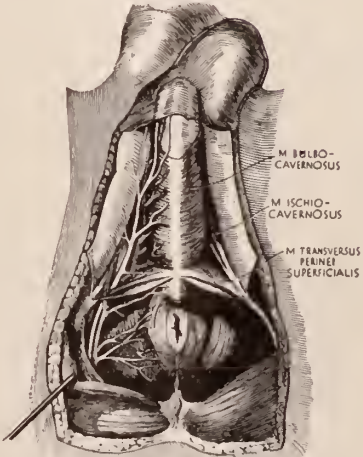
4. Perineal Appearance.

This ranged from slight ecchymosis to a large hematoma, but offered no exact criterion as to the urethral lesion. Only slight ecchymosis (particularly in stricture cases) may accompany a badly ruptured urethra. Many times the swelling in the perineum is extraordinary. In these cases the region about the vascular bulb is traumatized so that blood is poured out beneath Colles's fascia. This



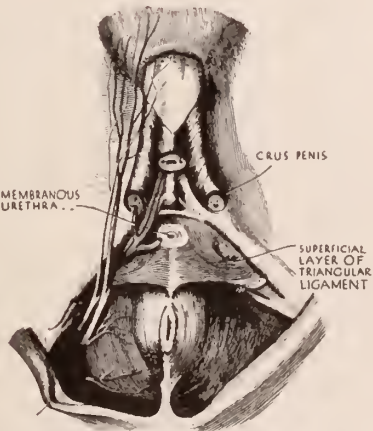
COLLES' FASCIA

Drawing B



THE SUPERFICIAL PERINEAL INTERSPACE

Drawing C



ROOF OF PERINEAL INTERSPACE WITH BULB REMOVED (After Warren)

Drawing D

TABLE 1.—*A Résumé of the Clinical Material*

Initials	Nature of Accident	Catheterization	Type of Injury	PreExisting Stricture	Urinary Retention	Treatment
M. B.	Caught in steam shovel, dropped astride sharp rock.	Impossible	Puncture wound involving proximal membranous urethra.	No	Yes	Cystotomy — later indwelling catheter.
C. B.	Slid down telephone pole, astride iron rung.	Impossible	Puncture wound proximal membranous urethra.	No	Yes	Cystotomy — indwelling catheter.
G. D.	Tumbled off cultivator, astride spiked wheel.	Impossible	Puncture wound membranous.	Penile hypospadias tight orifice	Yes	Cystotomy — retrograde indwelling later.
C. O.	In garage pit, astride bench support.	Impossible	Complete.	No	Yes	External urethrotomy.
P. P.	Astride timber brace in mine.	Impossible	Puncture wound involving bulb. Complete.	No	Yes	Cystotomy — retrograde indwelling later.
A. S.	Astride timber brace in mine.	Possible	Incomplete.	Yes	Yes	Indwelling catheter.
W. R.	Astride timber brace in mine.	Possible	Incomplete.	Yes	Yes	Indwelling catheter.
S. H.	Astride fence rail.	Possible	Incomplete.	No	No	Refused — subsequent extravasation.
G. V.	Astride stump from ladder.	Impossible	Complete.	Yes	Yes	External urethrotomy.
M. O.	Astride seat arm, in theater.	Impossible	Complete.	No Penile hypospadias	Yes	External urethrotomy.
C. L.	Astride limb in tree-pruning.	Possible	Incomplete.	No	No	Indwelling catheter.
P. H.	Astride saddle horn, horse stumbled.	Possible	Incomplete.	Yes	Yes	Indwelling catheter.
S. G.	Astride steel rail	Impossible	Complete.	Yes	Yes	External urethrotomy.
W. W.	Astride curb.	Possible	Incomplete.	Yes	No	Refused; extravasation.
S. L.	Astride step ladder.	Possible	Incomplete.	Yes	No	Refused; no extravasation.
E. B.	Tumbled off garage astride fence.	Possible	Incomplete.	No	No	Indwelling catheter.

hematoma effaces the perineoscrotal angle and swiftly advances into the scrotum. In other cases the scrotal tissues receive direct violence as part of the accident. These two confluent structures (the perineum and scrotum) then comprise a purplish mass extending nearly to the knees.

5. *Bleeding From the Penis.*

This was common, independent of micturition, and often persistent, but of small volume. It offered no index as to the urethral damage.

6. *Pain and Tenderness.*

This was always present in the perineum. Urinary retention provoked the greatest pain in most cases.

7. *Shock.*

This was greatest and most prolonged in the puncture cases. Bleeding from these wounds was also usually profuse, but never serious. The shock is often negligible in the ordinary straddle injury.

8. *Complications.*

Urinary extravasation was fairly common. This occurred in three cases, but only in one treated with an indwelling catheter. This tumefaction was promptly evacuated with a perineal incision, which

sufficed for cure. In the other two cases an external urethrotomy was done and the bladder drained by means of a tube through the proximal urethral segment. Free incisions were made into the advancing mass. In one case the extravasation was very troublesome, advancing into the scrotum despite free incisions, and finally onto the abdomen just above the pubis. It is our belief that the final chapter with regard to extravasation in its various phases has never been written, although its behavior from an anatomical standpoint is quite clear. Four cases in this series also developed an epididymitis.

9. *Sequelae.*

The most common sequela was a post-traumatic stricture at the site of urethral injury. It was roughly proportionate to the original damage, and was least in the cases treated by an indwelling catheter. It was never troublesome, but required occasional dilatations consonant with the contraction speed, generally at brief intervals in the beginning and a matter of months later. Three of our external urethrotomy patients complained of temporary impotence, and in one it persisted for nearly twelve months.

MANAGEMENT

Concerning Treatment.

The fundamental objective is to divert the urine from the site of urethral injury and, incidentally, in many cases to relieve acute urinary retention. We have, therefore, three avenues of approach, used singly or in combination: (1) the catheter, (2) external urethrotomy, (3) cystotomy.

1. An indwelling catheter for seven to ten days is usually adequate for partial urethral rupture. It splints over the lacerated area and favors healing. The traumatic urethritis incident to the catheter does not appear to retard healing. A patient, dextrous and gentle attempt at catheterization should be made in every case before surgery is undertaken. It is often facilitated by anesthesia. If it is not successful, then surgery must be resorted to without delay.

Technique of Catheterization.

Technical difficulties increase with lapsed time after the injury. Only a filiform is used at the outset because (a) many patients have preëxisting strictures in the penile urethra or about the bulb; (b) the bulbar urethra is often compressed, angulated, or displaced either by reason of the violence or contiguous hematoma or both; (c) the filiform hugs the roof better than other instruments; (d) and the filiform does not tend to increase the urethral laceration as a catheter nib or sound point might do. Once the filiform enters the bladder the rest is easy. This procedure is carried out under aseptic conditions, and then the catheter end is kept as sterile as possible. Five of our cases were successfully treated in this manner, with slight urinary extravasation in one.

2. An external urethrotomy is not always successful under these circumstances. With a large perineal hematoma it is best avoided, in our opinion, because of distortion, extravasated blood and altered anatomical landmarks. Moreover, the proximal urethral segment tends to retract particularly in the lithotomy position. The use of a filiform as a searcher and manually bringing the patient nearer a supine posture (lowering the legs and working beneath) after the exposure is made, have both helped us at times to discover the illusive upper segment. Once the proximal segment is located, the usual indwelling catheter is employed in the regular way. No attempt to suture the urethra was made by us, because in the dorsal decubitus the two ends come together anyway and healing appears just as rapid without the sutures. External urethrotomy was done four times in this series for the rupture and twice for extravasation developing later.

3. Cystotomy is the sheet anchor in all of these cases. This is especially true in puncture cases where the exact depth and extent of the wound is unknown. The urine should be drained a few days and then a secondary attempt made to pass the catheter in the regular manner or retrograde with the help of a perineal incision. Cystotomy was necessary in four of these cases. Twice we resorted to retrograde catheterization with the aid

of a perineal incision. In the other two catheterization was easily done seven or eight days subsequently.

CONCLUSIONS

Based upon our experience with these sixteen cases, we venture the following generalizations anent their management:

1. Every case of urethral rupture, whether partial or complete, should be hospitalized. This particularly concerns the gentleman who voids spontaneously after the accident, because he is the most difficult to handle and most often develops complications.

2. The truth with regard to treatment lies somewhere in the middle of the road between ultra-conservatism and meddlesome radicalism.

3. Each case is a law unto itself and must be handled accordingly.

4. Many partial ruptures when catheterization is possible do well with no complications on an indwelling catheter.

5. If catheterization (and it should be attempted) is impossible, surgery must be undertaken without delay.

6. Surgery should be bold and direct, but as simple as possible. Surgery devoid of fancy work, frills, and time-consuming maneuvers gave us the best end-results.

7. Surgery must not be too extensive at one session. Better to drain the urine and get out. After a few days of rest, one is agreeably surprised at the ease of subsequent accomplishments.

8. When sound surgical judgment is used, the results are gratifying and no group of patients more appreciative.

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DISCUSSION

THOMAS E. GIBSON, M.D. (450 Sutter Street, San Francisco).—Straddle injuries fall into two clinical groups: (1) immediate and (2) late. Doctor Beach has clearly outlined the salient features of treatment with respect to the immediate group. Emphasis should be placed on strict asepsis in handling these cases. One should have as much respect for the urethra as for the peritoneum. It is not enough to cleanse the external genitalia, but in addition the anterior urethra should be thoroughly irrigated with an antiseptic solution before catheterization or instrumental manipulation. Measures taken to minimize infection will minimize the occurrence of peri-urethritis at the site of injury with resultant scar tissue proliferation and stricture formation, which is the bane of this type of injury. Great discretion is likewise necessary in the use of the indwelling catheter in these cases, because an indwelling catheter in any case produces urethritis. This may cause peri-urethritis at the site of injury, with an increased tendency to later stricture formation. If an indwelling catheter is used at all for splinting purposes, it should be for as short a time as possible, and a size 18 or 20 F. is recommended, rather than a 24 or 26 F. The more tightly the catheter fits the urethra the greater is the resultant urethritis. Doctor Beach's statement that an "attempt at catheterization should be made in every case before surgery is undertaken" is at variance with the opinion of several authorities. Garlock (1923) states that any case presenting the symptoms of inability to void, perineal hematoma, bladder distention and urethral bleeding should be considered an emergency, and operated upon as soon as possible. Perineal, scrotal or pelvic extravasation of urine, when not relieved with a reasonably short space of time, invariably becomes infected, to be followed in succession by necrosis, sloughing of the soft parts, spread-

ing of infection, grave sepsis, and death. This fact constitutes the strongest argument for early operation where rupture is suspected, or diagnosed with certainty. Under no condition should preliminary catheterization be attempted in the face of this syndrome, which is practically always accompanied by a complete or almost complete rupture of the urethra. Attempts at catheterization increase trauma, create false pockets in the perineum, cause fresh hemorrhage, introduce infection, and in some cases convert an incomplete to a complete tear. Furthermore, even though one succeeds in passing a catheter to the bladder under such conditions, the ultimate result after healing has occurred is generally stricture formation due to the intense peri-urethral infiltration and reaction. Stricture formation is what we desire especially to prevent, because once present it is generally vicious and may require operation later. In other words, Garlock feels that by not using the indwelling catheter the tendency to stricture formation is lessened. The procedure to be followed in these cases, then, is drainage of the perineum and suprapubic cystostomy, letting nature attend to the healing of the urethra. After the initial traumatic reaction has subsided it may then be advisable to use an indwelling catheter, provided the urethra does not close spontaneously.

Even though the original straddle injury has been so slight as to produce no actual rupture or tear in the urethra, the patient may experience stricture formation and even complete retention coming on weeks, months, or even years later. It is imperative, therefore, even in slight injuries which do not interfere with urination at the time, to have these patients report periodically for dilatation with sounds for a long time, thus obviating late stricture formation. Traumatic strictures are notoriously more resistant and difficult to deal with than strictures of gonorrheal origin. It is of interest, as Lowsley has pointed out, that many of these straddle-injury cases suffer the occurrence of sexual impotence.

The late cases, which are often seen as a result of inadequate early treatment (and sometimes in spite of adequate early treatment), offer serious problems which may tax the skill and resourcefulness of the urologist to the utmost. The chief problem of the late case, seen perhaps months or years after the original injury, is the management of stricture, which is generally of a most rigid and refractory type. An attack of complete retention of urine may be the presenting symptom which makes the patient seek urgent relief. Filiforms and followers are called into play, but if they cannot be passed, cystostomy or external urethrotomy is mandatory, depending upon one's judgment in the individual case. Incidentally, if the stricture cannot be traversed with a filiform, it is sometimes possible to achieve success with a well-oiled filiform passed through a panendoscope under direct vision. If the stricture can be traversed, it may then be possible to maintain dilatation of sufficient degree by periodic passage of sounds. If the stricture is too resistant to dilate readily, as is often the case, and is attended by chills and reactions, an internal urethrotomy should be done. Following this procedure it is permissible to insert a large indwelling catheter (26 or 28 F.) for a week to establish patency, and to follow this up at necessary intervals with sounds. In my experience, an internal urethrotomy in late cases is always better than an external urethrotomy, if it can be done. An external urethrotomy, with excision of the scar and reunion of the proximal and distal urethra on an indwelling catheter splint, may be followed by partial incontinence, and reformation of scar tissue requiring further dilatation with sounds. When external urethrotomy is indicated, the method of Pasteau, modified to suit the individual case, should be followed.

It is important to bear in mind the damaging effects of stricture of long standing on the upper urinary tract. Ascending pyelonephritis and hydronephrosis are sequelae which may result in death from uresepsis or uremia.

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JAY J. CRANE, M.D. (1921 Wilshire Boulevard, Los Angeles).—We have just listened to a well-written paper on a subject which is of great interest to all urologists, although all of us do not have the opportunity to see such a large series of cases as those just described by Doctor Beach.

The subject has been well handled, and the paper when published will command the attention of all surgeons; for

nowhere in our present-day texts or even in our current literature, is there such a complete description of this subject.

Having cared for only a very small number of such patients in comparison with the large series Doctor Beach has seen, I feel that anything I may say will not lend much weight. However, I should like to emphasize the necessity of recognizing the nature of the injury early, in order that treatment may be carried out before extravasation of urine and blood is too extensive, especially in those patients who void spontaneously after the injury.

I also wish to mention that a cystogram taken at the time of the first catheterization will be of great assistance in ruling out a ruptured bladder. If after a catheter is passed, and no rupture of the bladder is found, then many of these patients can be cared for successfully with only a retention catheter; if catheterization, however, cannot be accomplished, then one should never hesitate to drain suprapubically and explore the abdomen at the same time if necessary.

PELVIC FLOOR AND ADJACENT VISCERA: THEIR PLASTIC SURGERY*

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DISCUSSION by H. A. Stephenson, M.D., San Francisco; H. N. Shaw, M.D., San Francisco; R. Glenn Craig, M.D., San Francisco; L. A. Emge, M.D., San Francisco.

A CONSIDERATION of the recent literature dealing with operations designed to correct damage to the birth canal and its supports, and to correct certain alleged pathological positions of the generative organs, leads one to believe that some of the significant factors in the statics of the female pelvic viscera are being overlooked. Certain it is that the behavior of many surgeons has been little influenced by the notable work of R. H. Paramore,¹ published almost twenty years ago.

OBJECT OF THE PAPER

The object of this paper is to outline briefly what appears to this writer to be the salient features in several useful plastic operations upon the pelvic floor and contiguous viscera. It is not intended in any sense to give a complete description of operative technique in the operations discussed, but rather to point out what should be the common feature in the various procedures designed to produce the desired results. Careful study of the various surgical methods described in textbooks and even more recent publications will show that credit for good results is often given to unimportant detail, while the significant factors go unstressed.

NORMAL ANATOMIC AND PHYSIOLOGIC FACTORS

In order to discuss the mechanics of repair, it is first necessary to consider the normal anatomic and physiologic factors concerned in pelvic visceral support.¹ It is important to understand that, except for its gaseous content, the abdominal and pelvic contents represent one visceral mass which

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is incompressible, deformable and, within limits, movable, and that this visceral mass throughout the life of an individual is continually being squeezed by its muscular walls. The pressure in this mass is subject to sudden and wide variation, and is caused by contraction of the thoracic diaphragm, the abdominal wall and pelvic floor muscles. Such pressure, originating in the upper abdomen, courses generally downward and, due to the lumbar spinal lordosis, is directed against the anterior abdominal wall a short distance above the symphysis. From here it is directed backward, and its repeated impactions produce the hollow of the sacrum from which the forces are reflected throughout the pelvic contents.

The diaphragm, which forms the pelvic floor, is composed of striated muscles with their fascial coverings, the levatores ani and the coccygei. Anteriorly, just behind the symphysis pubis, is a defect in the pelvic floor, through which escape three visceral canals to reach the surface of the body: the urethra, the vagina, and the rectum. This defect has been called the pelvic floor aperture.¹ The levatores ani—the only muscles which concern us in supportive operations—are bilateral muscular sheets which arise in front from the symphysis and laterally from the fascia covering the obdurator internus, and from the spine of the ischium. The fibers pass backward and medially surrounding this aperture, to insert into a median osseofibrous raphe and the terminal part of the sacrum. Below this upper sheet of the levators lies another muscular layer, a most important one in surgical repair, the puborectalis, which is inserted into the lower margin of the symphysis pubis, and completely encircles the aperture in the pelvic floor. In all of the operations designed to increase the tone of the pelvic floor, the puborectalis is the most accessible. Contraction of the fibers in the upper levator layer, the pubococcygeus, causes lateral constriction of the pelvic floor aperture, while contraction of the puborectalis layer exerts a sphincter-like squeeze of the aperture from behind the rectum forward toward the pubic bone.

VITAL STRUCTURES IN VISCERAL SUPPORT

There is ever recurring discussion among surgeons concerning the importance of the fascia and condensations of visceral connective tissue in pelvic visceral support; but it seems reasonable to agree with Paramore that the vital structure in preventing visceral protrusion through the pelvic aperture is the living tonic, striated muscle disposed about this aperture, and resisting downward thrusts.

The condensations of the visceral connective tissue stretch when the pelvic floor becomes inefficient, because of the inability of the musculature to withstand the pressures. The muscular floor depends, it is true, upon its connections, that is, the aponeuroses and bones. Without these rigid attachments the muscles would be useless. However, the changes which cause prolapse lie in the muscles and not in the connective tissue, which is greatly thickened in such cases.

THE PELVIC FASCIA

The pelvic fascia, about which there has been so much confusion in the past, is now known to be similar to fascias elsewhere in the body. It simply forms sheaths for muscles and has no direct connections with any pelvic viscera. It is this parietal pelvic fascia, together with the periosteum of the bones, which forms the real limits of the pelvic cavity, just as the transversalis fascia limits the abdominal cavity.

FASCIA ENDOPELVINA

The intricate layers of the so-called fascia endopelvina, which were thought to form ligaments supporting pelvic viscera (such as the true ligaments of the bladder, anterior and lateral, Mackenrodt's ligament running laterally from the upper part of the vagina and the cervix, and the sacrouterine ligaments) are simply condensations in the visceral connective tissue. While it is true that some of these thickenings contain smooth muscle fibers, their only rôle in influencing the position of the pelvic viscera is in virtue of the space they occupy and, because of their incompressibility, they are a part of the pelvic contents. These connective tissue thickenings are not present at birth, but are the later result of tensions set up in the loose, connective tissue which fills in the space between the limits of the pelvic cavity and its contained viscera.¹

MENGERT'S CADAVER STUDIES

Recent experimental work upon cadavers by Mengert,² in which he found the uteri were easily pulled down into the position of prolapse only after section of the dense connective tissue in the base of the broad ligaments and upper paravaginal regions, was thought to prove that the muscular pelvic diaphragm plays no important rôle in pelvic visceral support. There are several factors in these experiments which make it inapplicable to conditions in the living, such as the opened abdomen, the pulling downward on the uterus from below and the loss of contractibility of the muscles. What seems to have been proved is that section of certain connective tissue structures allows the uterus to be pulled down easily when the pelvic diaphragm is unable to contract.

A disturbance in the nerve supply to the levators in infancy results in uterine prolapse soon after the activity of crying raises the intrapelvic pressure.

RÔLE OF THE UNDAMAGED STRIATED MUSCLE

It seems obvious that undamaged striated muscle is the only tissue in the body which can continuously respond successfully in time and in degree so as to maintain a physiologic equilibrium of the pelvic viscera in the face of downward thrusts produced from above by the sudden contraction of striated muscles. With failure of the muscle, pelvic viscera begin to descend through the pelvic aperture in spite of fascia and greatly thickened connective tissue, and this generally occurs at a time of life when the pressure in the visceral mass is reduced. This reduction in abdominopelvic pressures is caused by atrophy of the muscular walls.

THE SMOOTH MUSCLE LIGAMENTS

The various smooth muscle ligaments of the uterus have been by some assigned a rôle in pelvic support, and have been used by surgeons of the past in vain attempts to cure uterine descent by their shortening. Although these are now generally considered useless procedures for prolapse, they are used in suspension operations on the uterus in attempts to cause anteversion of the organ. Studies on the cadaver, observations during surgical operations with the peritoneal cavity open, even bimanual examination of the uterus with the abdomen closed—all have a tendency to lead us into erroneous conclusions regarding the uterus. The rigidity of the uterus is due to the tonic contraction of its muscular walls; but to our tactile sense it suggests weight and immobility and, in contrast to the practically impalpable surrounding viscera, it seems isolated. In retroversion the greater ease of palpation intensifies this impression and strongly suggests abnormality, especially as we recall idealized anatomical illustrations of the proper uterine position.

POSITION PECULIARITIES OF THE UTERUS

It is well to remember that the uterus is completely surrounded by an incompressible medium and that its position is largely determined by changes in the volume of neighboring viscera such as the bladder and rectum, and by the disposition of small intestines as caused by the thrusts of increased pressures coming down from above. In most women the pressures from above tend to press the uterus forward and downward upon the bladder, and the higher the intrapelvic pressure the greater the uterine immobility. Orthopedic factors which change the direction of the downward thrusts may distribute the viscera differently so that small intestinal loops lie anterior to the uterus. No amount of ligamentary shortening will change permanently the position of the uterus if the postoperative position is resisted by pressures initiated by striated muscles. Suspensions of the cervical and vaginal stumps, after partial and complete hysterectomy, are useless gestures for the same reason—that is, that smooth muscle cannot long withstand forces generated by striated muscles.

INDICATIONS FOR OPERATIONS TO CHANGE UTERUS POSITION

Fortunately, indications for operations designed to change positions of the uterus are disappearing, as we better interpret physical findings and symptoms. A high percentage of the backaches in women are orthopedic problems, even when appearing only in association with the menses. Chamberlain, at Temple University, seems to have shown an increased mobility of the pelvic articulations during menstruation, similar (except in degree) to that occurring during pregnancy.

The weight of the uterus is almost, if not completely nullified by the pressure and incompressibility of its surrounding medium, and can be considered as floating in this medium unless it is adherent to immovable structures by inflammatory or malignant change.

The lower the abdominopelvic pressure the more movable becomes the uterus, so that hypermotility and retroversion are found most often in asthenic individuals. This low pressure is probably the explanation of the engorged veins so often described as caused by retroversion. The circulation of the abdomen and pelvis is markedly influenced by the abdominopelvic pressure, and rapid emptying of the veins only occurs when normally high pressures are maintained. The sensation of weight in the pelvis complained of by many patients is not due to a heavy or displaced uterus, but is the patient's interpretation of symptoms arising from distended vein walls.

PLASTIC OPERATIONS UPON THE CERVIX

Plastic operations upon the cervix, whether for repair of lacerations or for the removal of infected glandular structures, have become markedly simplified since Sturmdorf described his tracheloplasty in 1919. This operation supplanted many of the earlier procedures, because it removed pathology with a minimum of disturbance in physiological function. However, the conception that the Sturmdorf flaps of mucous membrane, when inverted into the cervical excavation, reproduce a normal relationship between vaginal vault and cervix, is erroneous. If the flaps stay as originally sutured, the cervix is pushed out of the vagina, thereby flattening the vaginal vault. Bilateral scars result, which are often mistakenly diagnosed as lacerations when only palpated. Conization of the cervix with the endotherm, using the Hyams tip, removes the pathology as effectively as the Sturmdorf enucleation, and gives a much better plastic result. If done quickly there is very little destruction of tissue, as is the case in cauterization and, therefore, little or no slough or secondary stenosis.

Just as the Sturmdorf technique could be applied at a higher level as an amputation of the cervix, so the endotherm can be used with a straight blade in cervical amputation. Control of the bleeding should be by deep suture. Whether the suturing of loosened mucous membrane flaps in the excavation is necessary or even advisable, may be questioned.

Routine inspection of the vaginal vault eight to ten days after the operation will often show the flaps loosened and hanging loosely in the upper vagina. Some of us are of the opinion that healing of the excavation by granulation and epithelization, such as occurs in conization, will give better plastic results and more nearly preserve the normal appearance of the vagino-uterine junction.

PROCIDENTIA

Procidentia can be considered as a hernia of the uterus through the pelvic floor aperture, and represents a pathologic equilibrium established with the descent and dilatation of the aperture as contrasted with the physiologic equilibrium which exists when the pelvic floor is competent. It is always accompanied in its descent by varying amounts of bladder and rectal wall. Surgical cure in procidentia depends upon reduction of the hernia and restoring tone to the damaged levator

fibers. Reduction of the hernia consists, in the case of bladder and rectum, in dissecting these structures free from uterine and vaginal attachments; and, in the case of the uterus in its removal, interposition, reposition or amputation of the swollen cervix. The method of opening the vaginal wall is of little consequence, as long as adequate exposure is obtained; and the shape of the denudation of the vaginal wall, if any, is also unimportant, as long as snug closure can be made.

Interposition of the uterus below the bladder is an effective method of treating prolapse, and except for the fact of retention of a potentially dangerous organ, and a slight outward bowing effect upon the ureters, can be considered a useful operation. Those who advocate interposition for prolapse make as one necessary condition in its use, that the uterus must not be atrophic. Now the uterus will later become atrophic, but recurrences after this operation are very few, so that, except as a temporary feature, the good result must be due to some detail of the operation other than that produced by the position or size of the body of the uterus itself. It must be understood that no treatment of prolapse or cystocele can be considered complete until the levator muscles have been restored in tone.

OPERATIONS FOR THE RESTORATION OF TONE

Operations for the restoration in tone of the damaged muscular mechanism for closure of the pelvic floor aperture are not anatomical restorations in any sense. The operation is called perineorrhaphy, although the surgery in the perineum is only incidental to, and not at all a necessary part of the surgery of the pelvic floor. The perineal body, about which so much has been made in the literature of the past, lies below the pelvic floor and contains the intrinsic closure mechanism for the rectum and vagina. Complete rupture or incision of the perineal body in the absence of damage to the levators contributes nothing to the production of prolapse.

All methods of increasing the efficiency of the levator muscles consist in pulling bundles of their fibers (mainly in the puborectales layer) out of their usual course and suturing them together in the midline between the vagina and the rectum. This converts a damaged and elongated U-shaped muscle into an approximate figure-of-eight, thus in effect shortening the muscle and thereby increasing its tone, and enabling it once more to close effectively the pelvic floor aperture.

OPERATIVE TECHNIQUE OF SOMERS

The writer would like to call attention to an operation for repair of the levator muscles first described by Dr. George B. Somers in 1903.³ The special point in technique as outlined by him concerned the suturing of the muscle bundles. After a high, triangular denudation of the posterior vaginal mucosa, the levator ani bundles are approximated by a layer of continuous silkworm gut sutures. The sutures are inserted through the vaginal mucous membrane above the apex of the denudation and are continued as mattress sutures,

closing the wound longitudinally and emerging through the skin of the perineum. The number of sutures is determined by the depth of the wound, the first being passed along its deepest part. After the mattress suture has transversed the length of the wound to emerge through the skin it is pulled taut, and this brings the tissues in the sides of the wound into contact. Each succeeding suture is placed more superficially until the entire wound is closed. The projecting ends of the silkworm sutures are left long and protected by a lead shot.

This method of perineorrhaphy closure holds the muscle and connective tissue firmly in the midline between the vagina and rectum, with little or no strangulating effect; is not as painful as usual methods of suturing, and produces no palpable transverse ridge in the reconstructed vagina. Healing is uniformly good due to the tolerance of tissues for silkworm gut and the absence of strangulation. Swelling can occur, the tissue sliding along the sutures, none of them being tied; and if infection of the wound occurs, the sutures will be effective drains while still splinting the wound edges. We have used flexible steel sutures for demonstration, and although the postoperative results were very good, the difficulties in insertion and removal are greater than silkworm gut.

ESSENTIAL ELEMENTS IN VISCERAL \ DESCENT OPERATIONS

The essential elements, therefore, in operations designed to correct visceral descent are:

1. Replacement of the herniated structures after dissection has sufficiently mobilized them.
2. Perineorrhaphy to reestablish effective closure of the pelvic floor aperture. This is done by suturing the two arms of the levators ani, with their fascial coverings, together between the rectum and the vagina.
3. The use of condensations of visceral connective tissues about the bladder and cervix uteri, the sacro-uterine, the lateral parametrial and pubocervical thickenings. These structures give immediate, although temporary, postoperative immobilization to the replaced structures and allow a firmer union to occur in the myorrhaphy.
4. When small intestinal loops accompany the bladder or rectum through the relaxed aperture, the condition is called enterocele; and cure of this condition requires, in addition to the extensive mobilization of the herniated viscera, the removal of the peritoneal sac and closure of the gap created, using the connective tissue structures previously referred to.

Recurrences in the large enterocele after operation will occur more frequently than in any other repair, because the muscular defect is the greatest. It may be necessary to use partial or complete colectomy to cure the condition. This obliteration of the vagina can be done very simply after recurrence has occurred, and should be reserved for the treatment of recurrences or in large prolapse with enterocele in patients considered to be poor surgical risks.

COMMENT

The controversy, then, between those who believe the connective tissue or fascia the most important supporting structure, and the adherents to the theory that muscle is the real support, can be reconciled at least as regards the utility of these structures in surgery. It will be noted that the excellent operations designed for prolapse by Fothergill, Neel, Rawls, and many others, always include a posterior colporrhaphy. It seems to this writer that, although he is thoroughly convinced by the researches of Paramore, that the visceral connective tissue (the uterine, vesical and paravaginal ligaments) is of no value in determining the position or contributing to the support of pelvic viscera normally, except as it is a part of the incompressible visceral mass and not a part of the pelvic floor, still it can play an indispensable part in reconstructive operations. He believes also that many plastic operations would fail but for the temporary protection given by use of these thickenings of visceral connective tissue to the healing myorrhaphy.

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DISCUSSION

H. A. STEPHENSON, M. D. (490 Post Street, San Francisco).—Doctor Pettit sets forth clearly and fully the value of certain pelvic structures in plastic surgery of the pelvic floor and contiguous viscera.

His theory of the causation of pelvic herniae is interesting and, to me, logical. If generally accepted, it should obviate the unjustifiable employment of certain operations involving the various pelvic ligaments for uterine malpositions. Hospital records already show that the operation of uterine suspension is now less frequently done than a few years ago.

All obstetricians will agree with the treatment of the cervix as described. Conization is the best method for patients still in the child-bearing age. Much obstetrical grief has resulted after the repairs and amputations formerly done by ambitious surgeons. In most instances this was due to the sacrifice of too much cervical tissue.

The careful reading of this paper by surgeons, obstetricians, and gynecologists should result in better plastic surgery of the pelvic floor and, therefore, better results for the patient requiring such surgery.

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H. N. SHAW, M. D. (901 Pacific Mutual Building, San Francisco).—Doctor Pettit has explained simply and clearly the relations and functions of the supporting structures of the pelvis. In many papers on this subject the descriptions of the pelvic fascias are so complicated that the reader is left hopelessly confused.

I know of no operation in which there are more variations of technique than in repair of the perineum, yet, thanks to an excellent blood supply, the end-results are nearly identical. One man stresses the importance of a "butterfly incision," the next uses a wedge shape, another employs silkworm gut with lead shot for approximation, while his associate regards them as relics of barbarism and uses buried catgut.

In the treatment of lacerated cervixes we prefer radial cauterization in general to the various trachelorrhaphies. I have seen end-results of cervical repairs, done by excellent men, that looked like starfish. A cautery takes about

a minute or two, and about twenty-four hours' hospitalization, while a careful cervical repair often takes a half-hour and keeps the patient in the hospital ten days.

One of the main reasons for repairing the cervix is to prevent cancer. A very early cancer would be destroyed by adequate cautery, while a very fine-looking repair might spread the malignancy like wild fire.

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R. GLENN CRAIG, M. D. (490 Post Street, San Francisco).—The indications for operations advocated to correct anatomical abnormalities of the uterus are steadily declining. As Doctor Pettit has pointed out, the adjacent uterine structures are the "guy-ropes," but the position of the uterus is maintained by the pressure of the soft, mouldable mass above. This we need not discuss. You might wonder why anyone would wish to talk of the anatomical structures of the pelvic floor, since they have been well known and well recognized for several decades. The present paper is based on anatomical concepts and operative procedures emphasized two or three decades ago. If one is interested enough to watch the various procedures carried out in the operating room, the answer will be obvious: the overabundance of tissue available for suturing deludes the operator into forgetting the importance of the restoration of the anatomical structures to their former normal position. While no operation is easier to do, none in gynecology is so frequently done so badly. For this reason Doctor Pettit is to be commended for so clearly emphasizing the necessity of fundamental anatomical and physiologic knowledge. I agree with the principles outlined by him, and hope we all shall have a better anatomical conception before our next attempt, of what we are trying to accomplish.

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L. A. EMGE, M. D. (2000 Van Ness Avenue, San Francisco).—Doctor Pettit's very frank statement of his own ideas about the mechanism of pelvic support deserves serious attention; so many statements of previous writers, giving undue credit to the pelvic fascia, have gone unchallenged and are automatically repeated in reviews of the subject. It is, therefore, refreshing to find someone who has enough courage to challenge established notions. I fully agree with Doctor Pettit that the pelvic diaphragm as a whole must depend upon functioning muscle fibers. A fascial membrane devoid of these fibers would have to possess a tremendous tensile strength and unusual thickness to withstand the abdominal pressure of an active individual. Wherever the musculature of the diaphragm has been weakened, pressure ultimately will produce a pelvic hernia. It may be argued that in old age this musculature atrophies, and that prolapse is not the usual result. However, with advanced age the pelvic diaphragm contracts and thickens, if not previously weakened, and if one realizes that physical activity is also decreased during that period, one can readily understand nature's way of regulating the supporting mechanism of the pelvis to prevent herniation.

Doctor Pettit did not discuss the work done at Stanford by Doctor Blaisdell in 1917, which includes both experimental and comparative anatomical studies. Blaisdell fully realized the importance of living muscles, and demonstrated their presence and response to functional changes in various animals and the different ages in man. Blaisdell pointed out that the basal ligaments were not individual components in the true sense of ligaments, but that they represent interchangeable groups of musculo-elastic structures to which he gave the name "suspensorium fibro-elasticum." Paramore's splendid contribution is considerably broader in its deductions than Blaisdell's, but it in no way detracts from Blaisdell's conclusions.

As far as the application of this knowledge to pelvic repairs is concerned, it perhaps is not out of place to say that any extensive repair would include muscle tissue either purposely or accidentally. Unfortunately, the very best of dissection and the strictest adherence to principles of plastic surgery will not always yield the desired end-result. The patient is relieved for some months, but herniation recurs because the supporting diaphragm has lost its contractility. In such instances there remains nothing to do except to resort to one of the operations which obliterates the vagina.

IMMUNOTRANSFUSION: ITS USE IN THE TREATMENT OF COMMUNICABLE DISEASES*

By PAUL M. HAMILTON, M.D.
Alhambra

DISCUSSION by Albert G. Bower, M.D., Hollywood;
C. M. Hyland, M.D., Los Angeles; Hyman I. Vener,
M.D., Los Angeles.

IMMUNOTRANSFUSION may be considered to be the combining of two well-proved therapeutic procedures, namely, transfusion and serum therapy. Theoretically, it would seem to be based upon sound logic, and practically it has fulfilled expectations in some diseases, while in others it has been less successful or has failed entirely, in some instances in the very diseases in which one might most confidently expect success. It is the purpose of this paper to outline the clinical impressions gained at the bedside in a hospital for communicable diseases, with only scant reference to purely scientific aspects or to the tremendous literature on the subject.

APPRAISAL OF RESULTS

An exact appraisal of the results of immunotransfusion is particularly difficult because of many variables, some of which are the natural variants of disease, the possible effect of transfusion, whether immune or not, the difficulty in grading the immunity of the donor, and the effects of other concurrent therapy. Parallel cases are usually a practical impossibility, with the result that adequate scientific standards for control are seldom, if ever, achieved. Results, therefore, are hard to couch in statistical terms, even those accepted by the consensus of all observers.

From the theoretical standpoint, one should expect the results to come both from the nonspecific actions of transfusions in general, such as the general supportive effect, the stimulus to hematopoiesis, the increase in oxygen carrying capacity, and the increase in volume of the circulating medium; and from the specific actions of added antibodies. In general, its advantages over animal sera lie in its multiplicity of actions, its negligible reactions, and, in some instances, in its greater specificity; its disadvantages are lesser potency, inadequate standards of potency, and the fact that it is often not available. Usually a highly potent serum is best used as a serum, whereas a serum of low potency gives better results in the form of whole blood. Convalescent serum and convalescent whole blood are so obviously closely parallel that both will be considered together.

Inasmuch as the antitoxic and bactericidal powers of a given blood are difficult to determine, we plan dosage as it would be planned for any transfusion, upon the size and general condition of the patient and his hemoglobin and red count. The quantity of blood used averages about 100 to

150 cubic centimeters in children, and ordinarily does not exceed 300 cubic centimeters in adults. The direct method is used unless technical difficulties prevent. The indirect or citrate method has seemed to give comparable results when it has been used.

TYPHOID FEVER

Transfusion has a definite and at times an apparently life-saving value in this disease, but a study of hospital records is not convincing that the degree of immunity of the donor is a decisive factor. These records show no critical drop in temperature, and no greater general improvement than might be expected on the basis of nonspecific results of transfusion. Reports from other communities, notably European, indicate a much greater effectiveness than has been our experience, due possibly to our lack of donors whose time interval since having the disease is not excessively long. Efforts to prepare a donor through the giving of vaccine have also been disappointing.

MEASLES

Our experience with measles is very largely with its complications, which are not amenable to this mode of treatment. We have, however, treated occasional toxic cases by immunotransfusion with encouraging results, and serum therapy in uncomplicated cases treated in the home has many advocates. Serum used as a prophylactic, in doses of 5 to 10 cubic centimeters, has given the same excellent assistance in cutting down cross infections in the hospital that has so often been reported among private patients. Both for therapy and for prophylaxis, donors free from fever for about two weeks are most desirable, though their immunity remains high for at least six months and may be expected to maintain a level of appreciable value for a much longer time.

MUMPS

This condition is one which we seldom have to treat. Reports indicate a definite value in preventing and treating orchitis, but our own experience is too small to be significant.

ERYSIPELAS

Some workers have assigned immune serum or blood a definite rôle in the management of this disease, but our cases have shown no benefit other than the purely nonspecific. This failure is rather to be expected in view of the poor immunity developed by erysipelas patients, and their tendency to recurrence.

SCARLET FEVER

This disease offers possibly the most striking opportunity for immunotransfusion in our entire experience. In the septic type, characterized by lymphangitis, adenitis, "picket fence" temperature, chills, and severe inflammation of the throat, results are always good and are often most dramatic. Commonly the temperature is normal by the following day, the rash faint or absent, the glandular swelling much reduced, and the patient subjectively improved in like proportion. Complications in these cases are extremely rare, the usual course being entirely uneventful.

* Successes and failures of whole blood and of serum from immune donors in specific treatment of communicable diseases, as seen at the Los Angeles County Hospital.

Read before the Pediatric Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

If treatment has been delayed until a complication has developed, such as otitis media or empyema of a sinus, results are much less gratifying, though a decided improvement may still be expected, especially in the disease process itself and sometimes in the complication as well.

Toxic scarlet fever, the type lacking evidence of extensive bacterial invasion but presenting marked prostration, sustained high temperature, heavy purplish rash, often hemorrhagic, and rapid pulse, has in our experience responded less dramatically to immunotransfusion, though these patients also are unquestionably improved by the treatment.

Simple scarlet fever, the type including the vast majority of our cases, will almost always reach a satisfactory conclusion with nothing more than symptomatic treatment; and due to press of work and lack of donors they are ordinarily not transfused. They respond very well, however, and many figures have accumulated to show a lessened incidence of complications. Other streptococcal infections, particularly of the throat and cervical glands, will also frequently respond in a manner almost specific.

In selecting donors the type and severity of their infection seems to be of relatively little importance, compared with the duration of convalescence. Those most frequently used are individuals who have had a mild attack, and who are at or near the end of the quarantine period. It would seem that the immunologic value of their blood begins to decrease quite appreciably by the end of the fourth week after defervescence. Dosage need not be large, 100 to 200 cubic centimeters being adequate for adolescents. Serum is as effective as whole blood, and is likely to be more potent than blood from a casually chosen convalescent donor, inasmuch as it is ordinarily pooled; and it is also more desirable because of its ease of administration. When using serum the dose is about a third the quantity that would have been used with whole blood. Results with either are the same, whether given by vein or intramuscularly, except for the delay in absorption using the latter route.

MENINGOCOCCIC MENINGITIS

This disease ordinarily does not enter into a discussion of convalescent serum therapy. However, it may be of interest to note that during the past year we have seen four patients whose organism could not be agglutinated by any commercial serum, and whose course was steadily downward under treatment with these sera. Inasmuch as they showed no evidence of septicemia it was assumed that their own blood must contain antibodies; this was verified in the laboratory, and all recovered under treatment with their own serum.

POLIOMYELITIS

Possibly no other disease at the present time offers such a focal point of controversy as does this one. Needless to say, final answers to the questions raised by it have not yet been forthcoming, despite vast amounts of laboratory and clinical research. Immune blood or serum for prophylaxis and treatment of this disease has received more attention than for any other condition, quite

possibly from sheer lack of any other visible approach to the problem; but results have been so conflicting and concrete evidence so scarce and difficult of appraisal that the advocates of immunotherapy have lacked conclusive support. It is difficult, nevertheless, to ignore completely the bedside impressions of able clinicians who have recorded improvement in many patients following this treatment, in instances giving every evidence of progressing unfavorably. In some of these cases improvement has been spectacular, including a critical drop in temperature and a return of reflexes to normal; this, of course, may have been due to natural vagaries of the disease, and the fact that such results do not consistently follow treatment rightly casts doubt upon its specificity. In the midst of such confusion, then, one can only offer the impressions of the men who did the work for whatever they may be worth.

Thus, Vener collected the subjective reactions of fifty consecutive patients from hospital personnel, almost all doctors or nurses, with the idea that their impressions should, presumably, be of more value than those of lay patients. Of this group, one felt worse after transfusion, three noticed no change, three felt only slightly better or were doubtful, and all the remaining forty-three considered that their transfusions had helped them decidedly. The most frequent improvement noted was in diminution or disappearance of pain, next in general sense of well-being, and next in diminution or cessation of nausea and vomiting. Objective improvement was noted in the disappearance of fever in almost all cases, and in the stopping of catheterization in seven. These patients had been ill an average of 6.6 days, with extremes of one to twenty days, and the changes noted occurred within twenty-four to thirty-six hours, regardless of previous duration of illness. Simple bed rest was not thought to be a large factor, as many of the patients had already been in bed some time without improvement; and in only four cases was any other therapy instituted at the time. These had spinal punctures, and one other patient had had a spinal puncture previously without relief.

Studying another group of patients at the same time, Meals found the same subjective improvement following the use of serum and glucose, but without transfusion; and further, that this group presented a shorter total duration of illness than did the group receiving transfusions. Thus, both observers felt that at least a subjective improvement is directly attributable to the immune bodies present in convalescent blood, but Meals holds that, except possibly in severe cases, it should be given as serum rather than whole blood. He argues that a patient having little involvement of the central nervous system may be made worse by transfusion, through an increase in the permeability of the choroid and consequent greater invasion of nerve tissue; whereas serum, lacking such effect on the choroid, permits neutralization of virus without opening new portals for its dissemination.

Such studies as these are not completely convincing, even to the enthusiast, and immunotherapy

in poliomyelitis has not been able to produce consistent statistical or scientific data in its own defense. The whole question, however, is thrown wide open again by the work of Claus Jensen during the 1934 epidemic in Denmark, in which he demonstrated what may prove to have been the unknown variable of many contradictory reports.

Jensen classified his donors on the basis of the severity of their symptoms, and tested the neutralizing power of sera from the different classes. He found the permanent paralytic, whose blood has made up the bulk of all serum used, to have the poorest neutralizing power; the patient with transient weakness, who only rarely becomes a donor, to have much higher antibody titer; and the abortive patient, who has been most carefully avoided as a donor, to have still greater neutralizing power. The potency ratios of the three groups were: paralytic, 1-1000 to 1-2000; nonparalytic, 1-80,000; abortive, 1-150,000. Thus, if Jensen's observations are correct we may have been carefully choosing the poorest available donor and creating confusion through variable potency of serum.

Jensen's work reached us too late for use during the epidemic, and we have had too few cases since then to be significant; but the present routine of the hospital, until a better one can be evolved, is to give every poliomyelitis patient immune blood or serum, preferably from an abortive donor.

IN CONCLUSION

Immune blood (or serum) is of great value in treatment of scarlet fever, particularly the septic type; it has some, but much less, value in treatment of measles; it is of great value in preventing and modifying measles; it is of little if any specific use in typhoid fever, erysipelas, and mumps; it may, under special circumstances, be of great value in meningococcic meningitis; its precise worth in poliomyelitis is still undetermined, but it offers the nearest approach to specific therapy now available, and is worthy of further use and investigation, particularly along the lines suggested by Jensen.

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DISCUSSION

ALBERT G. BOWER, M.D. (1724 North Highland, Hollywood).—Immunotransfusion is a term coined to set this procedure apart from ordinary or routine transfusions. By it we mean that, in theory, actively immunizing substances to a specific disease contained in the donor's blood are to be transmitted to the blood of the recipient for the purpose of passive immunization through the medium of transfusion. The donor is presumed to possess this active immunity by virtue of having successfully passed through an attack of the specific disease, preferably quite recently.

From the standpoint of therapy, in most diseases results are very disappointing; in some they are frequently startling. In the latter class fall simple and septic types of scarlet fever, poliomyelitis and, occasionally, severe measles and typhoid fever; though in typhoid the newer intravenous bacteriophage treatment (after Van Cleve) will, in most instances, undoubtedly supplant immunotransfusion. In the former class fall toxic scarlet fever, erysipelas, streptococcus septicemia, etc.

In those diseases in which immunotransfusion works, similar effects are not noted when merely carefully selected non-immune donors are used.

With the ultimate establishment of serum depots for pooled, specific, convalescent human sera, immunotrans-

fusion will be discarded in most instances in favor of intravenous serum therapy, because of more general availability of the latter, greater simplicity, and the establishment of standards of potency. It is to be hoped that in the future some better preservative than tricresol may be used for these sera.

Doctor Hamilton is to be congratulated for securing a serum depot for the Children's Hospital in Los Angeles.

From the standpoint of passive immunization of non-immune contacts, specific-pooled, convalescent human serum, given in adequate dosage very soon after exposure, will generally prevent the appearance of scarlet fever, measles, and mumps. In this connection its efficacy in poliomyelitis, as well as most other diseases, remains unproved.

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C. M. HYLAND, M.D. (4614 Sunset Boulevard, Los Angeles).—Of the conditions mentioned by Doctor Hamilton in which immunotransfusions have been used, I am especially interested in measles and scarlet fever.

His experience and observation in a large group of such cases gives much weight to his conclusions regarding the value of such therapeutics.

It is my feeling that his results following immunotransfusions may be duplicated with convalescent serum, provided the variables mentioned are properly evaluated in our appraisal of results, as these variables apply to convalescent serum as definitely as they do to whole blood. One of the variables, and an important one, namely, the immunity of the donor, applies less to convalescent serum than to whole blood due to the custom of pooling sera from many individuals; whereas, in an immunotransfusion, blood from only one individual is used. My experience with immune measles serum has pertained entirely to the prevention and modification of the disease. It can be conservatively stated that serum given early will prevent, and if given later will modify measles in a very high percentage of cases.

Scarlet fever convalescent serum also has two very definite uses. If given in adequate doses to contacts it will prevent the disease in a very high percentage of cases.

In a recent report from a study made in Chicago, each case of scarlet fever was responsible for 1.4 other cases. In the past season in Los Angeles multiple cases in a family were very frequent where seroprophylaxis was not used. On the other hand, in families where contacts were immunized with convalescent serum, the incidence of contact scarlet was negligible. When the disease did occur, it was definitely of a very mild sero-attenuated type.

We have observed instances where adult members of a family not immunized developed scarlet fever and immunized children of the same family escaped, although equally exposed. It would seem, therefore, that convalescent serum has a decided place in the prophylaxis of scarlet fever. Cases treated with adequate dosage show uniform improvement. In most instances this improvement is striking and dramatic.

I would like to make a brief reference to what might be considered an acceptable donor for immune whole blood or convalescent serum, and in so doing feel that the instructions given by the National Institute of Health for the production of convalescent serum are acceptable. From cases of measles the blood should be obtained not before the seventh day nor after the sixth month following the onset of the disease, whereas in scarlet fever, not before the twenty-first day nor after the sixth month following onset. In the serum prepared the past season, we did not use measles donors more than two months after the onset of the disease, and scarlet fever donors were not used more than three months from date of onset. Blood obtained in the above periods should contain a maximum of immune substances.

In concluding this discussion, I feel that both immunotransfusion and convalescent serum are of extreme value. In the contagious-disease hospital where immune donors are available, severe cases of scarlet fever may be given immunotransfusions. It will save lives and greatly reduce complications. In the home, or where transfusions for one reason or another would be difficult, convalescent serum if available may be used with equal results.

Transfusion or convalescent serum should be given early and in adequate dosage.

Doctor Hamilton's suggestion that the dose of serum should be about one-third that of whole blood is the generally accepted quantity. There is a tendency on the part of physicians to use too large a quantity of blood and too small a dose of convalescent serum. This latter tendency is probably accounted for by the fear some people have regarding the administration of serum in general.

This should not apply to a properly prepared homologous serum, which may be administered in adequate dosage, intramuscular or intravenous, and without fear, if the basic principles of such technique are observed.



HYMAN I. VENER, M.D. (1531 Purdue Avenue, Los Angeles).—Doctor Hamilton rightly emphasizes the clinical indications and observations of immunotransfusions in communicable diseases. He has presented the subject from a practical bedside aspect as encountered in our daily hospital routine.

For years I have urged transfusions in the acute infections, often to the point of obsession. When transfusions were first instituted, normal healthy donors with high hemoglobin sufficed, but as our knowledge increased we supplemented this method with immunized donors, either from a recent convalescent or by the use of a vaccine, preferably of the autogenous type. Such a procedure is not only of definite value, but is also a worthy addition to our armamentarium of medical therapeutics. Transfusions, when administered properly, not only aid in overcoming severe toxemias and combating the resultant anemias, but very frequently are a life-saving measure.

If convalescent serum is not available, whole blood by direct method without typing, in small amounts of 15 to 20 cubic centimeters, may be given intramuscularly into one or both buttocks. Care must be taken to have a Wassermann-negative donor, unless one is certain, as may be the case when a parent is often used. This injection can be repeated at intervals as needed.

In cases of typhoid fever when we know the course of the disease will be protracted, active immunization of one or more normal, healthy donors can be started at a very early date. A vaccine of the autogenous type isolated from the patient—either from the blood stream, feces, or urine—would be preferable; but stock vaccine could be used. The dosage of vaccine can be calculated and given at four to five-day intervals for approximately two to three weeks, with a last dose being given about six to eight hours before the contemplated transfusion. Better yet would be the immunization of old, recovered cases, or those previously immunized with the triple typhoid vaccine. Such cases are expected to have a much higher antigen titer, and the results of the transfusion would be more satisfactory. Similar methods of treatment could be instituted for cases of long-drawn-out sepsis, such as streptococci and especially undulant fever.

Foshay, in a personal communication, believed that immunotransfusions might be effective in Brucella's infection. However, he felt that the donor should be a recovered patient and subjected to active vaccination rather than the use of a normal immunized donor. He calls the former type a hyperimmune status. Undoubtedly the serum or blood thus obtained has a tremendous potency and is of great therapeutic value. He firmly believes however, that it is necessary to vaccinate such a donor for at least a period of sixty days with daily injections in order to obtain good results. Foshay attributes the disappointing results obtained from normal immunized donors to the fact that they have not been immunized enough.

Some of the disappointing results of immunotransfusions can be traced to a rather hurried, active immunization with little consideration given to strains and specificities of the organism involved. Three weeks of active immunization is usually the maximum limit; often the period is much shorter. Consequently, the donor has not had sufficient time or antigen to call forth his greatest effort for high titer production.

As Foshay aptly states, "we send a new-born infant to do a man's work."

Halberg of Stockholm found that immunotransfusions gave surprisingly good results where simple whole blood had previously failed. He advocated the use of autogenous vaccine—one billion bacteria to a cubic centimeter—given at four to five-day intervals for three to four doses, and a final dose about six hours prior to the transfusion. Other

workers advocate dosages of vaccine from 50 to 250 million per cubic centimeter at weekly intervals.

On a practical basis, it has been found that the bactericidal capacity of immunized donors gradually increases during the first six hours after the vaccine injection, and remains unaltered during the following forty-eight hours.

I believe that a donor, wherever possible, should be of the same blood-grouping and is preferable if choice is available. The reason is that the agglutinin content of the recipient is increased.

Transfusions cannot be relegated to a minor surgical technique. I am convinced that it is a major procedure, and infinite care and judgment must be used in the preparation of the patient, donor, and instruments. Attention to details and good teamwork in the procedure will save time and avoid the frequent delays. Moderately small doses of 150 to 200 cubic centimeters at frequent intervals in acute communicable or infectious diseases are of more decided value than one large transfusion of 500 cubic centimeters.

Transfusions cannot be supplanted by the various drugs, serums or vaccines advocated by different biological firms, despite their extravagant claims. Much of the reluctance in the use of transfusions by the profession may be ascribed to the fact that they do not have a product all wrapped up in a fancy package, and have not been deluged with reams of literature on the subject. Instead of making use of a transfusion *early* in the course of the disease, proprietary drugs are given, and when they fail to perform the miracles claimed, then transfusion is instituted. Under such circumstances the patient is either semioribund or in extremely poor condition. It is no wonder, therefore, that many physicians do not believe transfusions have any value. It only serves to cast disrepute on such therapy. Certainly, it would be best not even to attempt transfusions and thereby save time, effort, and expense.

Finally, if immune transfusions are to be of value and have a fair degree of success, we must enlist the cooperation and teamwork of the clinician at the bedside and the bacteriologist in the laboratory. The latter must know the clinical history of the case and thereby be in a position to evaluate the causative organism and its special characteristics for isolation. A thorough understanding of the problem and a willingness to work together may be the deciding factor between success and failure. With this aim achieved, proper active immunization of the donor can be instituted with the consequent possible saving of a life realized in what otherwise may be a hopeless struggle.

PREMEDICATION FOR SURGERY*

By JAMES C. DOYLE, M.D.
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DISCUSSION by Lawrence Chaffin, M.D., Los Angeles;
H. N. Shaw, M.D., Los Angeles; Mary E. Botsford,
M.D., San Francisco; Elmer Belt, M.D., Los Angeles.

WHILE inhalation anesthetics are less than one hundred years old, as you all know, the use of drugs to produce sleep or stupor and facilitate surgery dates back many centuries. Soporific potions known to and used by ancient and primitive peoples included henbane, hashish, hemp, opium, and mandragora. In our own country, according to Stevenson,¹ certain Indian tribes used infusion of jimson weed (*Datura stramonium*). Drinking this they slept through crude operative procedures without a move or grimace.

REVIVAL OF AN ANCIENT ART

Today we are emulating these practices by the use of "potions" in the form of a barbiturate and a hypodermic. Although great strides have been recorded in anesthesia and surgery, I believe that the adequate preoperative preparation of the pa-

* Read before the Anesthesiology Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

tient has been in many cases grossly neglected. However, there is a more general appreciation of premedication just now than a few years ago. The day is passing when the patient is sent to surgery with only a hypodermic of morphin and atropin, and in many instances the patients themselves are asking for adequate premedication.

AUTHOR'S PERSONAL EXPERIENCE

Twelve years ago I had a major abdominal operation. I mention this only because I shall never forget the dread and fear that the inadequate preparation then in vogue did not alleviate. The night before I was given no sedative. A strange room, a different bed, thoughts of the morrow, and, in addition, a fire-alarm near by with the usual accompaniment of noise and confusion, were factors not conducive to slumber. Finally, at a late hour, after pacing the floor, reading, and counting sheep, I dozed off. The surgical preparation consisted of no breakfast and a hypodermic of morphin with atropin one-half hour before surgery. For some reason unknown to me the operation was postponed an hour; meanwhile the hypodermic had been given. The morphin, so far as I was concerned, served no purpose; the atropin, on the other hand, made me very dry and thirsty, for which there was no relief. As the minutes crept by, I was wide awake, anxious and apprehensive. Fear became predominant. There are countless thousands, I am sure, who feel as I do, and I bring this personal aspect to you because until very recently little or no thought has been given "adequate premedication" of the patient. Is it not surprising that even today some surgeons follow the course I have outlined?

PRESENT-DAY METHODS

At present there are available various preparations (drugs) that will entirely eliminate fear, worry, and even apprehension. Why are they not more generally advocated and used? Surely, it is not a question of safety. For the past six years, without any untoward reactions, I have given a barbiturate the night before, repeated it an hour before surgery, and fifteen minutes later administered a hypodermic of pantopan and scopolamin. No, it is not safety that deters premedication; it is probably no more than an old-established "habit."

MENTAL REACTION OF THE PATIENT

We have heard very little of the mental reactions of a patient about to have surgery; yet this factor, in fairness, cannot be overlooked. Some of us know of patients who died during induction. Recently I saw a patient wheeled into surgery for a traumatic lesion of the leg; the anesthetic was begun without even the preoperative "hypo"; the patient died after not more than half a dozen breaths of gas. What killed him? Many opinions were expressed. *I believe he died of fright.* The adrenals pour out their secretion excessively during fright—a powerful heart stimulant which may cause death.

Without adequate premedication patients are prone to shock and they require more anesthetic—

25 to 50 per cent more in some cases. The majority spend a restless preoperative night. Upon arriving in the operating room they are apprehensive, worried, or excited, all of which contribute to poor anesthesia and a miserable convalescence.

A WORKING PROCEDURE

"Ideal" preparation, on the other hand, should include a barbiturate, preferably nembutol, the night before. For the average patient three grains is usually sufficient. One hour before surgery, nembutol, grains four and one-half, are given, and fifteen minutes later pantopon, grain one-third, or morphin sulphate, grain one-fourth, with scopolamin (ampoule), grain 1/150, by hypodermic. Thus, the patient secures a night of rest, free from apprehension and worry; in most instances will have no recollection of the trip to surgery or, if so, only a hazy one. Frequently he has no recollection of the first few days following operation. To illustrate how complete is the amnesia, patients often ask twelve to twenty-four hours following operation when they were going to surgery.

USE IN SUBARACHNOID BLOCK

The premedication routine just described is urgently recommended for subarachnoid block, and in all other cases where cocain or its derivatives are used. Barbiturates detoxify cocain and its derivatives: this is shown by the work of Tatum, Knoefel, and Guttman (quoted by Downs and Eddy),² and Swanson,³ and many others. (The author stressed their use in 1932.)⁴ Several years ago a prominent urologist told me of the behavior of many of his patients during sacral and spinal analgesia: immediately following the injection of novocain they would become pale, the blood pressure would drop, the pulse become rapid and thready, the body surface would be clammy and wet; the whole picture was that of cardiovascular collapse, in other words shock. I suggested that he use a barbiturate preliminarily, and he has done so, with the result that to date the above-mentioned sequelae have been eliminated. Many patients, sensitive to cocain or its derivatives, must be fortified against these undesirable sequelae. It is my belief that many of the sudden deaths reported due to "spinal" are, as a matter of fact, novocain poisoning or sensitivity. Other sequelae and complications reported, such as extra-ocular palsies, neuritis, headaches, spinal-cord degeneration, etc., may be obviated by the use of barbiturates.

In addition to the preliminary medication already mentioned for subarachnoid block, ephedrin grain three-quarter, is given when the patient leaves the room for surgery. When given ten to fifteen minutes preceding the block, this drug, by its action on the smooth muscle, causes a moderate rise in blood pressure of 10 to 30 millimeters. Ferguson and North⁵ experimentally established that there was no drop in blood pressure following its usage. Personally, from a clinical aspect, there is a moderate and gradual drop, depending on the level of analgesia desired and the condition of the vascular tree. In other words, on a patient

with a marked generalized arteriosclerosis, ephedrin would have much less effect than on one with little or no sclerosis.

COMPOUNDS OF BARBITURIC ACID

The barbiturates first came into use in 1903 after Fischer and Mehring⁶ synthesized "veronal." Since then many new compounds of barbituric acid have been produced and used as basal narcotics, also at times as anesthetics. Included in this group are luminal, somnifain, dial, neonal, allonal, amytal, pernocton, sodium amytal, and nembutol. Much has been written about these last two preparations, nembutol and sodium amytal; their popularity has reached the point where their use in some clinics and hospitals is almost routine. They are derivatives of barbituric acid, depressing the sensory and intellectual processes, and act by diminishing the proprioceptive faculties, thereby favoring sleep. They are sedative, antispasmodic, and hypnotic. The effect is prompt, and dreamless sleep is secured within twenty to thirty minutes following oral administration. When combined with morphin sulphate and scopolamin, body functions are altered but slightly. The blood pressure drops 10 to 30 millimeters, the pulse rate decreases and respiration is slowed. The barbiturates are broken up by the liver, and thought to be excreted through the lungs. In the instance of nembutol and sodium amytal they are not recovered in the urine.

ADVANTAGES OF THE BARBITURATES

I have mentioned some of the benefits afforded by this group (of which nembutol and sodium amytal are by far the most popular), benefits providing the patient with a restful night and amnesia on the day of surgery. Furthermore, they lessen the amount of anesthetic needed. Other favorable factors are the elimination of the excitement stage of the anesthetic; a favorable impression on the part of patients having had previous surgical experiences; a decrease in postoperative pulmonary complications (Hooper and Gwathmey).⁷ Gwathmey⁸ also stated that their preoperative use reduced by 28 per cent the use of morphin sulphate postoperatively, and by 15 per cent the incidence of vomiting as compared with the usual preliminary of morphin sulphate, which requires 82 per cent postoperative morphin and results in 60 per cent vomiting. The combination of nembutol with morphin sulphate and scopolamin has proved efficacious: the one fortifies the other and the tranquillization produced is greater than when one is given without the other. Respiratory depression is greater, but is slight as compared with the increased efficiency obtained. Clinical and experimental evidence, substantiated by personal experience, has led the author to use nembutol almost exclusively.

PHARMACOLOGY OF PREMEDICATION DRUGS

The pharmacology of the premedication drugs, I am sure, is well known to you all. A few points may, however, be mentioned. *Morphin and pantopon* are similar in action. They differ in that the latter consists of the isolated alkaloids of opium

in their natural proportions, the gums and resins being absent, thus assuring prompter absorption. Both act on the central nervous system, depressing its higher functions. The cardiovascular and respiratory systems are slightly depressed. The latter (pantopon) is less likely to cause nausea and vomiting, and tends to be less constipating. Both are broken up in the liver and partially destroyed there, while a smaller part is eliminated in the urine and feces. When combined with scopolamin and the barbiturates they are synergistic, and aid each other in producing more satisfactory tranquillization.

Scopolamin and atropin are similar in that both are alkaloids. The former occurs in various plants containing atropin and is now prepared mainly from scopol. The latter is derived from a number of plants, such as belladonna, scopol, etc. It is a respiratory stimulant. Both dilate the pupil; both suppress secretions of the salivary, sweat and mucous glands, the former being the more powerful in this respect. Because of its stability the ampoule form of scopolamin is recommended. In this form the dextro-rotatory, or stimulating alkaloids, have been removed, leaving only the levo-rotatory, or sedative alkaloids.⁹ I have never seen a deleterious reaction from the ampoule, while unfavorable sequelae are not infrequent when the tablets are used. There is an antipathy in the minds of some men regarding the use of scopolamin, and rightly so. An elder colleague informed me of a death due to 1/75 grain (tablet) many years ago. It is needless to say he never used it again, but this was before the time of the ampoule; besides, the need for so large a dose rarely, if ever, arises.

I have previously stated my usual recommendations for preoperative drugs. I may go so far as to say they are almost routine. There are, of course, reservations as to age, weight, general condition, and to some extent the type of anesthetic, but for subarachnoid block, nitrous oxid, oxygen and ether I follow the outline above. Exceptions relate to avertin and evipal and children.

Because *avertin* (tribrom ethanol) is a powerful respiratory depressant, the preliminary medication should be somewhat less. The evening before the usual nembutol, grains three, is recommended (except in the aged and cachectic when one and one-half grains are sufficient. One hour before surgery nembutol, grains three, is given, and it is followed fifteen minutes later by a hypodermic of morphin sulphate, grain one-quarter or one-sixth, and atropin sulphate, grain 1/150. The avertin is then instilled rectally about twenty to thirty minutes before surgery. No ill effects have been noted with the above method, nor has respiratory embarrassment been encountered.

In cases where evipal is to be used, the question of premedication depends upon whether or not the patient is hospitalized and also upon the operative procedure employed. *For out-patients premedication is not recommended.* For in-patients morphin sulphate or pantopon with scopolamin will suffice, and to some extent lengthen the anesthesia; post-

operative comfort, too, will be assured. From evipal alone patients generally recover rapidly with no untoward reaction. It is only when large doses of a barbiturate are used that the reaction is delayed. In itself the drug is a cardiovascular, respiratory depressant; and the addition of nembutol or amytal increases this action unduly. It is a splendid anesthetic for operations of short duration.

SURGICAL PREMEDICATION FOR CHILDREN AND INFANTS

Of late some progress has been made in preparing the adolescent and adult for surgery. Children and infants have been woefully neglected. I wonder how many of us would be willing to undergo surgery with no premedication whatsoever? I feel quite sure of the answer! We know that infants and children tolerate medication. Jarman¹⁰ has advocated and used nembutol in children successfully and without a failure in over two hundred cases by rectal administration. Leech,¹¹ in a still larger series of cases, recommends morphin, sulphate and scopolamin from two years on, and has used hyoscin, grain 1/1200 or 1/900, in infants with pyloric stenosis. His schedule begins at one year, with morphin sulphate grain 1/40, hyoscin grain 1/600, forty-five minutes before surgery, and proceeds up to twelve years, with morphin sulphate grain 1/12, hyoscin grain 1/300.

As with adults, we pay no heed to the psychic effects of surgery on these children, yet we know that the child is afraid of a hospital and of an operating room. Should they not be permitted to face the ordeal of a surgical experience with the same tranquillity as their elders? The induction is usually associated with crying and exhibitions of physical prowess, and undoubtedly a sequel to this terrifying experience is manifested by their fear during future contacts with the medical and nursing professions. This fact is substantiated by reports from numerous children's clinics, nurses, and social workers.

How, then, shall we aid these children? The answer is quite simple: nembutol plus atropin for the infants, with the addition of morphin in older children. How much shall we give them? No routine will apply here because of the prevalent variations in age, weight, and general condition. However, for a child of roundly four years, grain one of nembutol the night before and grains one and one-half one hour before surgery. If not asleep in thirty minutes, another grain may be instilled in the rectum. Subsequently a hypodermic of atropin, grain 1/450, forty-five minutes before surgery. In older or younger children, the doses will vary correspondingly.

I have seen no untoward reactions from this treatment, and the children were sleepy or asleep when they arrived in surgery. The induction was smooth and quiet; the anesthetic dosage was appreciably lessened. The children, I feel sure, have had no visions of terror or fright, no memory of the mask or ether, and their future medical care will be simplified with better and happier coöperation.

COMPLICATIONS

Complications, sequelae, or untoward reactions are infrequent, but do occur. This fact necessitates careful watching on the part of the anesthetist and nursing staff. As an example, occasionally a patient having had a preliminary barbiturate may get out of bed on the first or second day postoperatively. Although the incidence of this somnambulism is low, and more of a rarity with nembutol than sodium amytal, it should be guarded against by side boards routinely. It is noteworthy that none of these patients had to be reoperated for hernias or eviscerations. Some few patients do not react favorably to the barbiturates and are hyperactive postoperatively. These need closer observation on the part of the nursing staff. Morphin sulphate or pantopon usually controls them. Cyanosis of lips, associated with a cardiorespiratory depression, is usually of brief duration. Carbon dioxid or carbogen inhalations twice daily or three times a day may serve to prevent lung complications, and should be used routinely when ether has been given for a long operation. Rarely postoperative narcosis lasts several days, but causes no untoward result.

IN CONCLUSION

In an experience of six years there have been no fatalities or unfavorable sequelae from "adequate premedication." Nembutol grains three the night before with nembutol grains four and one-half one hour before surgery and pantopon grain one-third, or morphin sulphate grain one-quarter, with scopolamin (ampoule) grain 1/150 forty-five minutes before surgery (with variations for age, weight, and general condition of the patient), have proved satisfactory for all concerned—patient, anesthetist, and surgeon.

This combination was productive of amnesia, tranquillization, and a notable absence of fear and apprehension for the patient. The anesthetist found the induction easier and the anesthetic dosage was reduced by 25 to 50 per cent. When subarachnoid block was used, the patients slept throughout and no untoward reactions or sequelae occurred. Premedication for children is humane; it is desirable from the standpoint of the family, the anesthetist and the surgeon. Last of all, adequate premedication aids convalescence by decreasing the postoperative use of morphin and materially lessening lung complications.

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DISCUSSION

LAWRENCE CHAFFIN, M.D. (1136 West Sixth Street, Los Angeles).—The value of adequate preoperative medication cannot be overestimated. The demand for more satisfactory preoperative medication in all types of surgery has been answered during the past five years by the general use of the barbiturates. Experience has clearly proved that preoperative barbiturates, in addition to the usual morphin and scopolamin, are of definite practical value, and for the following reasons:

1. Fear is so completely eliminated that many patients do not remember having had their operation.
2. The safety of spinal anesthesia is materially increased.
3. The amount of general anesthesia required is definitely lessened.
4. All types of anesthesia are taken smoothly and without effort.

I have found the procedure outlined by Doctor Doyle to be efficient and satisfactory in all respects. I would, however, suggest caution in the dosage of barbiturates for those past sixty, and for those patients who have had a prolonged illness. It has been my experience, likewise, that not infrequently children under three years of age are rather sensitive to nembutal, and require careful dosage.

✽

H. N. SHAW, M.D. (901 Pacific Mutual Building, Los Angeles).—This paper emphasizes a very important point: the necessity for close coöperation between the anesthetist and the surgeon.

A careful study of the patient by the anesthetist, with suggestions as to the type of anesthetic, takes quite a load from the surgeon's mind.

Among our surgical patients, a good number had previous operations before proper attention was paid to the preoperative medication. These individuals never fail to express their appreciation of its value. As the author points out, the strain which the patient undergoes before the ordeal of surgery may be a considerable factor in a delayed convalescence.

In 1908 I was operated for an empyema. As far as I was concerned, that rib resection was the most important operation that had been performed anywhere for several years. I can never forget the trip to the operating room, through walls redolent of iodoform. A crowning humiliation was to hear one of three or four white-clad figures say, "Here's the next case, who's going to put him on the table?"

A surgeon, who has recently returned from a tour of the large eastern clinics, told me that in many of them they pay very little attention to surgical premedication. It is, however, an extremely important part of the surgical procedure, and I wish to compliment the author on his very clear presentation of the subject.

✽

MARY E. BOTSFORD, M.D. (807 Francisco Street, San Francisco).—This timely paper is on a subject that, for some years past, needed to be brought to the attention of the medical profession. The routine administration of morphin and atropin militates against the best results, preoperatively and postoperatively, with a large percentage of patients.

The psychologic factor is of the utmost importance in the adult patient and, as Doctor Doyle points out, doubly so in children, as the sights and sounds of transportation to, and a possible long period of waiting in, the surgery

may produce a psychic response which has been known to lead to a complex lasting for years. The addition of the barbiturates and tribromethanol to the previously known narcotics, such as the opium derivatives and scopolamin, have helped immeasurably in providing an escape from the depressing effect of fear, and in bringing the patient to the operating table in the best possible physiologic and psychologic condition.

The selection and combination of hypnotics and anesthetics must vary with the individual condition.

The use of atropin in combination with morphin was based on the tradition which still maintains, that being the physiologic antagonist of morphin, it provides a safety factor. It stimulates respiration, accelerates the heart, and increases the metabolic rate. This respiratory action is a disadvantage in modern gas anesthesia, and now that carbon dioxide is available in all well-equipped operating rooms, respiratory depression can be immediately overcome.

All of the arguments of the psychic and physiologic values of the methods advocated in this paper for inhalation anesthesia have double force as to their use with subarachnoid. Finally, the barbiturates have been proved to decrease the toxicity of the cocaine derivatives.

✽

ELMER BELT, M.D. (1893 Wilshire Boulevard, Los Angeles).—Dr. James Doyle is to be commended for his vigorous and pleasing style of writing, as well as the presentation of a very usable plan of surgical premedication. With the magic of the phenobarbital group of drugs at hand, there remains little excuse for permitting the occurrence of preoperative terrors and fatiguing worry. I vividly recall an old gentleman driven to seek surgical help because of severe urinary hemorrhage. Fear of his hemorrhage outweighed his fear of surgery. Entering the hospital late at night, he refused all medication and suddenly fled when an orderly came in to shave his pubes. The next day another hemorrhage occurred. He reentered the hospital, still vowing that he would not be drugged. He permitted the nurse to give him an enema and thus received nembutal by rectum. When he awakened, the papilloma, which had caused his trouble, had been removed. He is now friendly to hospitals and laughs at his former fears.

Doctor Doyle fails to mention a powerful factor in his success as an anesthetist. This is his custom of visiting and examining the patient on the day before surgery. This contact is comforting and reassuring to the patient. It gives him an opportunity to express his fears and have fear replaced by a rational understanding of the manner in which a scientific man is prepared to meet for him the problem of anesthesia.

URETERAL CALCULI*

By DOZIER H. GIBBS, M.D.
Los Angeles

DISCUSSION by Burnett Wright, M.D., Los Angeles;
A. A. Kutzmann, M.D., Los Angeles; Lionel P. Player,
M.D., San Francisco.

AS this paper deals with the practical management of ureteral calculi, the question of etiology of urinary lithiasis will be only briefly mentioned.

ETIOLOGY

The primary cause is unknown, and it remains for the physical chemists to solve the problem. When they discover the cause of the disturbed colloid crystalloid balance, the question will be nearer a solution. Urinary stasis; infections, local and focal; disturbances of metabolism, especially calcium; vitamin A deficiency; trauma of the kid-

* Read before the Urology Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25 to 28, 1936.



Fig. 1.—Case No. 1. Impacted stone lower ureter. Passed after enlarging ureteral meatus, and one dilatation of ureter below stone.

ney or spinal cord, and highly concentrated acid or alkaline urine are contributing causes, and should be corrected, in so far as possible, as a prophylaxis against the formation of other stones.

Primary ureteral calculi are formed in the kidney and pass into the ureter, where they may become lodged at any point, usually above a narrowing, or they may pass directly into the bladder. After being arrested in the ureter they usually increase in size, causing complete, partial, or intermittent obstruction. If a groove forms they may increase to considerable size without producing any symptoms or damage to the kidney. Unless there is free drainage of urine past the calculus, there will be some damage to the kidney, varying from slight dilatation of the renal pelvis to complete destruction from hydronephrosis or by invasion of the parenchyma by infection.

A very conservative attitude should be maintained while dealing with these apparently hopelessly destroyed kidneys, as they have remarkable regenerative powers after free urinary drainage has been established.

There have been some very large stones reported by Kretschmer, Goldman, and Bugbee. The largest in my small series was 12 by 4 centimeters in diameter.

DIAGNOSIS

The diagnosis can usually be made, although it is not always easy; and even when it appears obvious from the history and symptoms, a complete urologic study may be necessary and should always be done.

Pain of some variety is usually present and is typical when it radiates into the external genitalia. Microscopic blood is practically always found, with the exception of the anuria cases. There are

many conditions external to the urinary tract that may cause either hematuria or suppression. The x-ray is our greatest aid in establishing a positive diagnosis. If the ureter is entirely filled with the proper contrast media, even the non-opaque stones will usually be outlined. Intravenous urography has been a great aid, not only in establishing a diagnosis, but in determining the condition of the urinary tract above the stone. No great significance should be given to the entire absence of secreted opaque media if there has been a sudden complete block. As soon as the obstruction is removed they rapidly regain their normal function. Present-day writers, reviewing large series of cases, state that from 10 to 22 per cent cannot be demonstrated by the x-ray. A wax-tipped catheter is a great aid, and should always be used in doubtful cases.

There is a definite number of cases with typical symptoms, and a few red blood cells in the urine in which no calculus can be demonstrated. These are due to a mass of adherent crystals, which may be passed spontaneously or following the passage of a catheter. Phleboliths, calcified glands and various other opacities are readily identified and do not cause much confusion if opaque catheters are used and stereo films then made.

Air bubbles in the ureterogram are occasionally confused with non-opaque stones.

TREATMENT

The management of ureteral calculi should be highly individualized, and they should all be removed as speedily as all the factors warrant.



Fig. 2.—Case No. 2. Calcium oxylate stone upper right ureter. Impacted eight days. White blood cells 36,000. Constant vomiting. Five unsuccessful attempts at cystoscopic removal elsewhere. Ureterolithotomy through a lumbar incision liberated 60 cc. of purulent urine under pressure from the kidney pelvis. No sutures were placed in the ureter. No urinary drainage. Healed eight days.

Since Lewis introduced his stone dislodger there has been a continued parade of dilators, screws, bulbs, slings, crushing forceps, etc., to assist in the removal of ureteral stones. The better procedure is the use of the ordinary catheters and bougies, dilating the ureter, changing the position of the stone and, if possible, providing temporary drainage past the stone. The catheter or catheters should not be left in place too long. The enlargement of the ureteral orifices with surgical diathermy is often indicated and surprisingly large stones that have become lodged here will pass. The cystoscopic removal of calculi is ideal, and every effort should be made to relieve the patient this way when the size of the stone, the condition of the kidney, and the condition of the patient justify it. A note of warning, however, should be sounded as to the dangers of too prolonged attempts with this procedure. Conservatism must have, as its object, the welfare of the patient. From 50 to 90 per cent of ureteral stones have been reported as passing spontaneously or after some cystoscopic maneuver.

INDICATIONS FOR OPEN OPERATIONS

The indications for open operations are:

1. Stones obviously too large to pass.



Fig. 3.—Case No. 3. A laminated calculus in the lower ureter and a similar calculus in the hydronephrotic kidney. The ureter was large enough to permit the easy passage of the ureteral stone to the kidney pelvis.



Fig. 4.—Case No. 4. A calculus twelve centimeters by four centimeters in diameter blocking the lower ureter. Young man of twenty-one with a history of severe abdominal cramps with nausea, vomiting and diarrhea, associated with limping at irregular intervals for twelve years. Ureteral calculus had not been suspected.

2. Failure to pass, after repeated cystoscopic procedures.
3. Anuria.
4. Severe infections of the kidney.
5. Impacted stones that cannot be moved or passed.

Peacock states that often the shape, rather than the size, is the determining factor.

TECHNIQUE

The operative removal of an impacted stone is fairly easy, as it will usually remain stationary while the patient is being anesthetized. Any movement will practically always be toward the kidney. For stones in the upper two-thirds of the ureter a lumbar approach is used. If in the lower third the mid-line incision is preferable, although some operators prefer the Gibson incision. Adequate drainage must be provided, preferably by soft tubing, and if necessary through a stab wound in the flank. This dependant drainage is especially indicated after any type of muscle splitting approach through the lateral abdominal wall. The incision in the ureter should be large enough to permit the easy removal of the calculus in one piece, and should always be done under direct vision. Profuse hemorrhage will result if one inadvertently removes a phlebolith.

No attempt is now made to close the ureter. If the ureter is entirely free from obstruction, it will rapidly heal. In my very limited experience wounds in the lower ureter have urinary drainage more often and longer than those of the upper ureter.

Ureteral calculi discovered during early pregnancy should be promptly removed. Those found during late pregnancy should be treated more conservatively.

During the past five years I have treated fifty-one private cases of ureteral calculi that were demonstrated by x-ray. There are twelve other cases of ureteral colic relieved by one dilatation in which no calculus could be demonstrated. These, I am sure, were caused by masses of adherent crystals, as the urine in each case was loaded with crystals or amorphous phosphates. In thirty-three cases the stones were passed following conservative treatment, nine being removed by various stone removers. Following the use of a metal corkscrew, one case developed a severe hemorrhage, filling the bladder with clots which were removed by way of the urethra, when the stone was found embedded in one of the clots. Twenty-four patients passed stones after being dilated from one to nine times, four requiring the enlargement of the ureteral orifice by surgical diathermy. There were eighteen open operations. Twelve ureterotomies, with two deaths from pulmonary emboli, both occurring on the twelfth postoperative day. Six nephrectomies, with no deaths: three because of hydronephrosis of long standing, and three because of multiple abscesses resulting from prolonged retention of infected urine in the kidney pelvis. One of these was removed at the time of operation, one three weeks postoperative, and the other one two months after the stone had been removed from the ureter. I would like to cite a few illustrations and unusual cases.

REPORT OF CASES

CASE 1.—Cystine calculus in the lower right ureter.

Indian boy. Age, eighteen months. Loss of weight and attacks of vomiting and crying for past six months. Many red blood cells; no white blood cells; and no infection in the urine.

CASE 2.—Calcium oxylate stone in the upper right ureter.

First attack of twenty-four hours' duration. Complete anuria. Gibson incision. Postoperative pulmonary emboli (three), with recovery. Insufficient drainage resulted in huge collections of pus in the flank, which were drained on the tenth and eighteenth postoperative days. Should have been drained by a stab wound in the flank.

CASE 3.—Calcium oxylate stone in the upper right ureter. Impacted eight days. White blood count, 36,000. Constant vomiting. Five unsuccessful attempts at cystoscopic removal elsewhere. Ureterolithotomy through a lumbar incision liberated 60 cubic centimeters of purulent urine under pressure from the kidney pelvis. No sutures were placed in the ureter. No urinary drainage. Healed in eight days.

CASE 4.—Impacted stone in the lower ureter. Passed after enlarging ureteral meatus, and one dilatation of ureter below the stone.

CASE 5.—Bilateral calculi in the intramural ureter. Many attempts at removal, after enlarging the ureteral openings unsuccessfully. Both stones removed through a suprapubic cystotomy wound. Healed in ten days. Died on twelfth postoperative day. Pulmonary emboli.

CASE 6.—Bilateral multiple calculi. Right nephrolithotomy five years previously. Has passed over fifty calculi

from both sides. N. P. H., 76. Total phthalein, only trace in two hours. Both ureteral orifices were enlarged. He now passes stones with little pain. The urinary infection has not yielded to treatment.

CASE 7.—Calculi in the lower ureter. Kidney removed elsewhere eighteen months previously. Continued to have colic, with blood and pus in his urine.

CASE 8.—The two x-rays were taken six months apart, and show the rapid growth of the phosphatic ureteral stone that was pushed back into the kidney pelvis during an attempt at cystoscopic removal.

CASE 9.—(a) Shows a small stone in the pelvis that remained the same size for three years. (b) Shows the same stone enlarged, and engaged in the ureter after the patient was on a very rigid stone-dissolving diet for one month.

CASE 10.—(a) Sinus tract injected with lipiodol solution. From this a diagnosis of a tuberculous lesion of the spine was made. (b) Injected with iopax, shows its connection with the kidney pelvis, and a large stone obstructing the lower ureter. The other kidney appears normal.

CASE 11.—A laminated calculus in the lower ureter, and a similar calculus in the hydronephrotic kidney. The ureter was large enough to permit the easy passage of the ureteral stone to the kidney pelvis.

CASE 12.—A calculus, 12 by 4 centimeters in diameter, blocking the lower ureter. Young man of twenty-one, with a history of severe abdominal cramps with nausea, vomiting and diarrhea, associated with limping at irregular intervals for twelve years. Ureteral calculus had not been suspected.

SUMMARY

1. Ureteral calculi are formed in the kidney. The actual cause is still unknown.

2. The prophylaxis to prevent a recurrence consists in (a) removing all urinary stasis and infection; (b) keeping the urine well diluted and changing its reaction; (c) a diet rich in vitamin A; (d) in cases of calcium oxylate stone, eliminating from the diet food containing oxylates.

3. Urography and the waxed-tipped catheter are diagnostic necessities.

4. Ureteral colic may be caused by masses of adherent crystals that cannot be demonstrated.

5. Conservatism must have as its object the welfare of the patient.

6. Repeated use of the ordinary catheters and bougies is preferable to the various stone removers, and is the treatment of choice in about 70 per cent of the cases.

7. The size of the stone, the size of the ureter, the condition of the kidney and the condition of the patient must be considered in determining how long we are justified in using conservative methods.

8. Free drainage must be provided. A stab wound to provide dependant drainage is occasionally indicated.

9. It is not necessary or advisable to close the incision in the ureter.

10. A small series of sixty-three cases are analyzed.

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DISCUSSION

BURNETT WRIGHT, M. D. (727 West Seventh Street, Los Angeles).—There is so much that is good and so little to disagree with in Doctor Gibbs' paper that it can be considered and referred to as a safe, sensible guide to the management of ureteral calculi. In this locality, where urinary stones are so common, and open operations, especially ureterotomy, are relatively frequent, it may be well to emphasize the fact that dangerous and occasionally fatal complications sometimes follow the surgical removal of impacted ureteral calculi. The author's two deaths from pulmonary emboli, in a series of eighteen ureterotomies with a mortality of 11 per cent, while uncommonly high, illustrate the point. In more than fifty ureterotomies for stone in the past fifteen years, I have, luckily, had but one pulmonary embolus, which Doctor Gibbs and I both remember all too well, since he was the unfortunate patient, and I was the terrified surgeon! That emboli may follow inadequate drainage and retroperitoneal suppuration after ureterotomy, is a conviction now firmly implanted in my mind, and is an additional argument in favor of suturing the ureter, especially in its lower third, where drains do not function as well as through a lumbar approach to the upper ureter. A certain percentage of sutured ureterotomies will heal per primum, while there is practically always some urinary leakage in those left open; often it is profuse and prolonged, and results in peri-ureteral scarring, and predisposes to coccal infection in the kidney, with subsequent stone formation, as pointed out by Kidd a number of years ago. We recently cut down on a ureter to remove a stone impacted at the site of a previous ureterotomy, and found two inches of the ureter imbedded in a dense mass of scar tissue that bound it firmly to the surrounding structures. This must have resulted from urinary leakage, after the first operation. We feel that it is especially important to suture dilated ureters that have to be opened. It is our opinion that postoperative stricture of the ureter will occur less frequently if the ureter is carefully and properly sutured after ureterotomy. For a number of years we have opened the ureter with a cataract knife and sutured it with needles and instruments used in eye surgery in an effort to avoid trauma to the edges of the incision, and to attain better approximation and healing. We recommend periodic examinations with intravenous urography and ureteral dilations, when indicated, for all patients who have had a ureterotomy for stone, to ascertain and correct any tendency to postoperative stricture formation.

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A. A. KUTZMANN, M. D. (1930 Wilshire Boulevard, Los Angeles).—I would like to commend the author on his timely and common sense, conservative discourse on ureteral calculi, especially in the treatment outlined. In the present era of advancing urology and the bringing out of so many new mechanical ureteral-stone removers, we very often forget many good and time-tried procedures with simpler instruments. It is true that some of the new stone removers can be used to better advantage in the extreme lower ureter, but for general use through the entire course of the ureter the ureteral catheter is still the best. It is fraught with less danger in causing trauma, ureteral perforations, etc. We must exercise special care where there is suspected a pathologic ureter, resulting in obstruction, edema, brittleness, etc. The writer has enjoyed much success with calculi in the ureter, situated higher than 4 to 5 centimeters, by employing the use of several catheters, and leaving them indwelling for several days. As these catheters are being removed, the injection of either sterile olive oil or glycerin, or an equal combination of both, will tend to help a stone on its downward progress. Often the stone becomes enmeshed with the catheters and will come out with them.

I believe the figure of non-visualization, 10 to 20 per cent, is too high—5 to 10 per cent being more near the

usual run. Excellent modern x-ray equipment, and technique to bring out good tissue detail are responsible for this. The use of intravenous urography will enhance such studies still further. Occasionally with the patient in the throes of colic, or shortly thereafter, no opaque media will be excreted on the stricken side, but the kidney outline will stand out more than usual due to the apparent holding of the media in the renal parenchyma. The affected kidney is not functioning, even though there be no ureteral obstruction, as evidenced by cases with very tiny ureteral calculi, but having excruciating colic. The affected side apparently is in a type of "shock," leading to a suppression which may take from several hours to one or two days to cease; meanwhile the opposite kidney will function normally, as evidenced by a visible ureteropyelogram. This phenomenon has helped in diagnosing some cases with tiny calculi or urate stones not casting shadows in the plain x-ray plate. Further aid may occasionally be obtained from the x-ray by stereo pictures, lateral views and serial pictures.

Whenever possible a catheter should be passed up the ureter prior to operation and an x-ray exposure made. This will give the operator definite information as to the location of the calculus, and, furthermore, will keep it anchored in that location until removed.

In conclusion, I would like to stress conservatism in the management of ureteral calculi, since most of them will pass spontaneously or with aid of conservative instrumental manipulation. Doctor Gibbs has outlined very well the definite indication for the surgical removal of ureteral calculi.

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LIONEL P. PLAYER, M. D. (384 Post Street, San Francisco).—The essayist in his brief discussion of the etiology of urinary lithiasis aptly concludes with the usual phrase: "etiology not definitely known." It is generally conceded that urinary calculi are primarily renal in origin. Calculi may gravitate from the renal substance to the calyx, pelvis, the ureter and the bladder, or they may become arrested at any point along the urogenital tract, and cause symptoms in proportion to the degree of obstruction and irritation they produce.

This paper is concerned with ureteral lithiasis, its diagnosis, and treatment. On an average, 90 per cent of stones are demonstrable by x-ray and this average is somewhat increased by the intravenous or retrograde injection of a selected opaque media, which shows the comparative density between the calculus and media.

The author mentions the frequent necessity for full cystoscopic study in order intelligently to determine whether surgical or manipulative procedures are indicated. He stresses the danger of delaying surgery in favor of manipulative measures, and presents in concise form the indications for open operation. He might add to these, however, two more indications, namely, increasing hydro-nephrosis and diminishing renal function.

The various metal instruments for removing ureteral stones are dangerous, even in the hands of the most skilled urologists, and should be used only in selected cases. The simplest and best instrument for removing ureteral calculi is the ordinary ureteral catheter with its varied tip modifications. It may be left in the ureter either above or below the stone for the purpose of dilatation, and the various oils, diluted acids, etc., can be injected to facilitate the stone's expulsion.

The site of the incision in open surgery should be governed by the position of the ureteral stone, and x-ray should immediately precede the operation for obvious reasons.

In many instances I have refrained from suturing the incision in the ureter, and so far have had no reason for regret. Dependant drainage, I certainly agree, is highly important, but the drain should be close to and not in contact with the incision in the ureter.

In the after-treatment of the patient, dietary precautions and clearing up of urinary infection are important; but further investigation of the urinary tract for strictures and other abnormalities is of paramount importance.

ACUTE METASTATIC SPINAL EPIDURAL ABSCESS

By WILLIAM J. VAN DEN BERG, M.D.
Sacramento

DISCUSSION by Howard W. Fleming, M.D., San Francisco; Carl W. Rand, M.D., Los Angeles; F. L. Reichert, M.D., San Francisco.

ACUTE spinal epidural abscess, metastatic in origin, is undoubtedly more common than a review of the literature seems to indicate. There have been two cases in this vicinity within the past two months. The few papers published, describing this definite clinical entity, have endeavored to focus the attention of physicians in general on the signs and symptoms which point so clearly to an abscess in the spinal epidural space.

ETIOLOGY

The etiology is similar to that of perinephric abscess. One can usually obtain a history of a previous infection elsewhere, usually a furuncle or subcutaneous abscess, occurring a short time before the onset of the epidural abscess. In studying the previously reported cases, it is interesting to note the high percentage with a trifling back injury in addition to a previous infection. In a few cases there is a history of a back injury without an infection history. The age incidence has been from two to fifty-five years.

DIAGNOSIS

The patient is acutely ill, and has a moderate or high fever and hyperleukocytosis. One of the distinctive symptoms of this condition is that the patient will complain of severe root or girdle pains radiating from the back to the front of the chest, or to the front of the abdomen, or around the pelvis and down the thighs, depending upon the segmental location of the abscess. Upon examination, one finds extreme tenderness of the spinous processes over the affected area, accompanied by spasm of the adjacent back muscles. Stiffness of the neck and bilateral Kernigs are present—when the abscess is in the lumbar region the Kernigs are extreme, the neck stiffness slight.

These are early signs, and if the condition is untreated they are soon complicated by signs of cord involvement—paraplegia, sphincter disturbances, sensory loss, and, as the abscess advances up the space, an advance of the sensory loss, and paralysis will be noted.

A spinal tap is essential to confirm the diagnosis, though this admittedly increases the hazards to the patient. When the abscess is in the lumbar space, there is grave danger that the spinal needle may carry the infection from the epidural space into the subarachnoid space, and thus initiate a meningitis. However, the lumbar space is over one centimeter in depth, and is distended with pus, and one can successfully pierce this space by a careful tap without entering the subarachnoid space. In fact a routine spinal tap is apt to enter this space only and evacuate pus, and if the operator does not have an epidural space abscess in mind he is likely to make a diagnosis of purulent meningitis. Any doubt in the matter can be dispelled by a

recheck through the cistern which will show a practically normal spinal fluid.

When the abscess is in the dorsal epidural space, a block is produced early; a positive Queckenstedt is present; and the Froin syndrome will be noted—the spinal pressure will be low or quickly fall because of the block; the fluid will be yellow and will clot spontaneously owing to its greatly increased protein content.

ANATOMY

The epidural space, according to Dandy's¹ study of its anatomy, is formed by the division of the dura into two halves at the foramen magnum: the inner half, running down the canal, acts as the dura proper while the outer half serves as the periosteum of the vertebrae; and in between these two layers is the epidural space. This space contains fat, connective tissue, and venous and arterial plexus. Above the seventh cervical vertebra the space is merely potential, the two layers being in contact. But from the seventh cervical vertebra downward this space has a depth varying between .5 to .75 centimeters in the upper dorsal region, narrowing slightly in the lower dorsal and upper lumbar regions, and deepening to over one centimeter in the lower lumbar and upper sacral regions. The space is present only dorsal to the nerve attachments.

TREATMENT

There is only one successful treatment—a laminectomy—which should be done as soon as a positive diagnosis is made. And the incision should be packed wide open. In several cases reported in the literature, a second operation was necessary because of pus pocketed in the spaces just above and below the limits of the original laminectomy. Operation offers a cure even in the presence of cord involvement (paraplegia), if the latter has not been present too long. Otherwise there is some residual paralysis after recovery from the infection.

I am convinced that the use of staphylococcus antitoxin in my case, following the laminectomy, was of distinct value.

REPORTS IN THE LITERATURE

Slaughter, Fremont-Smith, and Monroe² reported one patient who recovered following a laminectomy, and in reviewing the literature found twenty-nine cases reported with six recoveries—two of the six with residual paralysis of the lower extremities.

Cathey³ reported one patient who was operated on and died; but as he states there was also osteomyelitis of the spinous processes, we must conclude the abscess was by direct extension and cannot, therefore, include it in our metastatic cases.

Stanley⁴ reported two cases with recovery. In neither was there any history of subcutaneous abscess or questionable focus preceding the epidural abscesses. In both cases, however, there was a history of a trifling back injury.

Gasul and Jaffe⁵ reported three cases in children, with two recoveries, and in an exhaustive bibliography reviewed the entire literature, begin-

ning with the first reported case by Morgagni (1682-1771). Up to July 1, 1936, and including the two cases reported herein, there have been seventy-one cases reported in the entire literature. Twenty of these patients recovered, five of whom had some residual paralysis.

In reviewing the literature one is impressed by what seems to be two distinct era in the diagnosis, treatment, and prognosis of these patients. The first era, from the time of Morgagni to the end of 1928, was despairing: out of thirty-six cases reported only one recovered (Pulvirenti⁶)—a mortality of over 97 per cent. In the second era, beginning in 1929, there is a distinct change for the better. Out of thirty-five cases reported in this second period, nineteen of the patients recovered—a mortality of 46 per cent. And this brighter new era is due chiefly to the work of such pioneers as Dandy,¹ Mixter,⁷ Smith,⁸ MacDonald,⁹ Ely,¹⁰ and others.

REPORT OF CASES

CASE 1.—The first case of epidural spinal abscess reported herein is one in which the patient had a subcutaneous abscess two weeks before his entry into the hospital. A laminectomy was done and the patient made a complete recovery. Howard W., a well-developed and nourished high school athlete, age seventeen years, was admitted to the Sacramento Hospital June 11, 1936, with an admitting diagnosis of back sprain. He stated that six days previously he fell and hurt his back slightly, but thought nothing of it at the time. The following morning he had pain in his lumbar region, which gradually increased. For the past three days the lumbar pain had been severe, with sharp, shooting pains referred down both thighs anteriorly. He had had occasional headaches, but no nausea or vomiting. His mother stated he had been very irritable, and had had a high fever for the past four days. On further questioning, he recalled having had a subcutaneous abscess of his right arm two weeks before his present illness.

The abnormal physical findings were a moderately stiff neck, extreme bilateral Kernigs, marked spasm of the lumbar muscles, and extreme tenderness to pressure over the lumbar spinous processes. At entry his temperature was 102.6; pulse, 110; respirations, 24. Urine had one plus albumen. Blood hemoglobin was 75 per cent; white blood cell count, 15,400. An x-ray of the spine was negative.

A lumbar puncture in the third interspace evacuated about two drams of thick pus. Laboratory smear of the pus showed an abundance of Staphylococci which, on culture, proved to be *Staphylococcus aureus*. A provisional diagnosis of acute *Staphylococcus meningitis* was made, and the case was referred to me. However, a reexamination and study of the patient made me question this diagnosis. Mentally, the patient was too alert for any meningitis of a degree revealed by the spinal needle. Furthermore, the girdle pains radiating around the pelvis and down the legs, indicating a nerve-root irritation which was definitely localized in the lumbar region strongly suggested a lumbar epidural abscess. To confirm my diagnosis, I did a cisternal tap by which I obtained a perfectly clear, normal, cerebrospinal fluid.

Operation was performed about twelve hours after entry into the hospital, and about six and one-half days after the onset of symptoms. A laminectomy of the second, third, fourth, and fifth lumbar vertebrae was done, the initial incision being just to the left of the spinous processes, freeing and retracting the periosteum and muscles outwardly to the left; then severing the spinous processes at their bases and retracting them with their attached ligaments, muscles, and outer periosteal layer of the right laminae to the right. As soon as the epidural space was opened, about a dram of thick pus was released. Culture of the pus showed *Staphylococcus aureus*. The laminae of the second, third fourth, and fifth lumbar vertebrae were removed, releasing about two drams more of thick pus, and, as there was a small collection of pus epidurally in

the upper end of the sacral canal, the first sacral spinous process and laminae were also removed. There was no osteomyelitis of the vertebral processes, nor was there any granulation tissue in the epidural space. The wound was packed wide open. On each day for five days succeeding the operation, the patient was given intramuscular injections of 10,000 units of *Staphylococcus antitoxin*. His temperature went up to 104 following the operation, gradually dropped to normal on the fourth day, and stayed about normal thereafter. On the thirty-sixth postoperative day a secondary closure was made under local anesthesia. The patient was discharged August 6, 1936, completely recovered.

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CASE 2.—While I was preparing to report the above case, a pathologist called my attention to another case of epidural spinal abscess which he had on the autopsy table. And while I did not see this case before autopsy, I have reviewed the case history notes and present a résumé herein. D. M., white, female, age sixteen, was injured in an automobile accident August 1, 1936, and sustained a fracture of the right ankle. Physical examination was otherwise negative, except for notched upper incisor teeth (Hutchinson). Her urine was negative; white blood cell count, 16,500; blood, Kahn and Wassermann four plus. The patient had an upper respiratory infection, and spinal anesthesia was used on August 4 in setting the fractured ankle. On the second postoperative day she began to run a daily septic temperature, with its maximum between 101.6 and 102.6 degrees. On the fifth postoperative day she began to complain of severe girdle pains, radiating to the front of the lower chest and upper abdomen, and repeated examinations of the chest and abdomen failed to account for these pains. On the eighth postoperative day she insisted on sitting up in a wheel chair, and a few minutes later complained of numbness and weakness of her legs, which later in the day developed into a complete paralysis and sensory loss below the costal margin. White blood cell count was 57,400. This sensory loss and paralysis gradually ascended. The patient died within twenty-four hours of the onset of the paralysis. Autopsy showed an abscess of the entire epidural space from the foramen magnum downward into the sacrum, accompanied by cord-softening. Culture of the pus showed an abundance of *Staphylococcus aureus*.

Medico-Dental Building.

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DISCUSSION

HOWARD W. FLEMING, M.D. (384 Post Street, San Francisco).—Doctor Van Den Berg has emphasized the similarity of acute epidural abscess syndrome to that of perinephritic abscess. As regards the etiology the comparison is most apt, and properly stresses the relationship of local trauma and staphylococcus infection. Only too frequently the chief attention is focused on the site of primary infection or to the region of the referred pain,

until far-advanced cord symptoms make the diagnosis. In a recent case, paraplegia was considered an hysterical manifestation before proper surgical treatment was instituted.

The necessity of a thorough back examination in cases of adults complaining of thoracic and abdominal pain, is fully as real as in the child suspected of Pott's disease. Local tenderness to pressure or pounding over a spinous process is often a helpful diagnostic sign, and may be found several hours before the onset of cord symptoms. The following record of an unusual case illustrates this point.

A middle-aged man, with a moderately severe diabetes, had been operated on for a right mastoiditis. The post-operative course was difficult and interrupted by several minor complications. Several weeks after the operation the patient began to complain of pain, weakness and numbness of the left arm and hand. Early examination suggested the possibility of a stereognostic impairment, and the diagnosis of a right cerebral brain abscess suggested. The absence of stupor and signs of increased intracranial pressure made this diagnosis seem unlikely. The very definite tenderness of the cervical spine focused one's attention to that site. In a few hours it was possible to demonstrate a definite Brown-Séquard syndrome with a total block of the spinal canal. Operation revealed a very large epidural abscess in the cervical region.

The necessity for immediate operation in these cases should be emphasized. The cord signs are due to interference with circulation and a toxic softening of the cord as well as the direct pressure. If satisfactory drainage is not accomplished in the first few hours, the patient may have a permanent paraplegia. I feel a negative exploration is justified in an attempt to diagnose and treat this condition early in its course. Close observation and very frequent examination are fully as important in cases of suspected epidural abscess as in cases with a suspected surgical belly.

Doctor Van Den Berg's paper brings to our attention a syndrome that is probably far more frequent than we suspect, and one that is often diagnosed too late to allow effective treatment.

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CARL W. RAND, M.D. (523 West Sixth Street, Los Angeles).—There is now no doubt but that acute epidural abscess is a distinct clinical entity which can be diagnosed with unusual accuracy. The patients almost invariably have an infection elsewhere in the body. We have seen epidural abscesses secondary to a carbuncle of the neck, a boil of the leg, a furunculosis and osteomyelitis of the humerus.

In my experience the initial symptom has been a terrific pain in the back. This is of great intensity and is localized over the site of the abscess. The motor symptoms usually appear before the sensory. The latter, however, may become complete within a few hours after the onset. Slaughter, Fremont-Smith, and Munro have pointed out that a complete spinal block may be present before the motor and sensory symptoms have become advanced. Basing the location of the abscess on the tenderness in the back and the presence of a positive Queckenstedt's test, they have been able to drain such abscesses before severe damage to the spinal cord has occurred. This is important, for in advanced cases where damage to the cord is extensive one may expect little, if any, recovery from the symptoms. Allen and Kahn have outlined in considerable detail the structural changes which may occur in the spinal cord in such cases. Their illustrations show not only edema, but cystic areas of degeneration and necrosis. In some of their sections the cord near the posterior columns shows a honeycombed appearance. Again degeneration of the anterior horn cells is shown. These changes appear relatively early, and make it imperative that surgery should be instituted before paraplegia has appeared. Unless operation is employed early, damage to the cord will be more irreparable.

As Doctor Van Den Berg states, these cases are now being more favorably treated than heretofore. Epidural abscesses are more common than have been supposed, and in the future many more cases should be accurately diagnosed. In the past many of them presumably have been hidden under the name of "transverse myelitis."

F. L. REICHERT, M.D. (Stanford University School of Medicine, San Francisco).—The importance of recognizing and treating properly the acute spinal epidural abscesses is emphasized in Doctor Van Den Berg's paper. He has clearly and briefly summarized our knowledge of this condition and pointed out the essential diagnostic findings, indicating the important and distinctive symptom of severe root or girdle pains as an early complaint.

The findings at autopsy, in the second case, of epidural pus extending the entire length of the spinal canal, would make the pathologic condition more extensive than an abscess.

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DOCTOR VAN DEN BERG (Closing).—Early diagnosis and treatment are essential to save life and cord function. To save life after we get some degree of the permanent cord damage described in Doctor Rand's discussion is, at best, an unhappy victory. Doctor Fleming adds an interesting successful case to the growing list. Epidural abscess, as Doctor Reichert points out, is not an accurate pathologic description—empyema of the epidural space is perhaps a more exact pathologic diagnosis—but the former has been accepted by the profession and will undoubtedly remain.

THE LURE OF MEDICAL HISTORY†

PRACTICE AMONG THE ESKIMOS

By BRUCE H. BROWN, M.D.

San Ysidro

IN preparing this paper, I have drawn mostly from memory. Having been in government employ,* all my case records and reports became the property of the Government.

Practice among the Eskimos is the subject of my paper, but I shall also speak of the customs, especially those akin to disease, which will tend to give some insight into the Eskimo character.

ON FEEDING OF CHILDREN

To render young children strong and healthy, these savages feed them the flesh of young pups or dog's excrements mixed with their food, which sometimes causes their death. I have in mind a case of epithelioma of the lip (one of two cases of cancer seen in five years), which I had treated, of course, unsuccessfully. The native becoming discouraged, drank, either on the advice of the medicine man or some ignorant white, a mixture of dog urine and gunpowder. It killed him.

Parents who have lost several children give the surviving ones to some childless couple who, by adopting them, save them from the death to which they are doomed in their own family. This plan may work well in cases in which the parents are negligent, or too stupid to take proper care of the children, or are tuberculous; provided, the adoptive ones are not the same. But experience shows that the mortality of adopted children is not noticeably less than that of others.

BOILS

To cure permanently a crop of successive boils, to which these natives are not infrequently sub-

†A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellaneous department, and its page number will be found on the front cover.

*Editor's Note.—Dr. Bruce H. Brown was formerly a passed assistant surgeon in the United States Public Health Service.

ject, they have two methods, of singular efficacy. The core, being carefully extracted, is placed in the barrel of a gun and fired off with the load, or else it is swallowed by the patient. The second method might be considered an homeopathic treatment, while the first is decidedly allopathic.

Both, however, in this Eskimo point of view, proceed from the same idea of utterly destroying the offensive germ. In the second case the native theory is that organic matter is thoroughly destroyed by the process of digestion. Another habit, fortunately obsolete, is that of wives carefully gathering, in cups or other receptacles, the expectorations of their consumptive husbands, blood as well as pus, and swallowing it. To burn anything excreted from the body would, to them, be running the risk of terrible disaster.

PUBERTY

The puberty customs exclusively concern the woman. They appear to have no notion of age in puberty in males; and though they sometimes impose a new name to a male child about his twelfth year, it seems to have no reference to any organic development. In the case of a girl, the renaming generally takes place when she reaches the age of puberty. They have the idea that women at this time are particularly receptive toward all external influences; hence the principle of assimilation by contact is brought to bear, and all available objects that are possessed of qualities desirable for her are sought for and put in close proximity to her. They also believe that the discharge contains the very essence of femininity, hence the woman must avoid all contact with men; especially young men, as this would render these young men womanish and unmanly.

Of course, no young man who has a spark of ambition would willingly expose himself to blight thus the rest of an earthly career, nor would a young woman bring this misfortune upon him, and so the puberty rules are rather scrupulously observed.

I have never heard of a case of legal impurity contracted by a woman in this condition.

MENSTRUATION AND CHILDBIRTH

Making due allowance for honorable exceptions, it must be said that it is a notion among these people, and one that does no credit to their morality, that menstruation is a consequence of previous sexual intercourse. Thus, in certain localities, girls generally, with the full consent of parents or guardians, have intercourse, preferably with a married man, to have the first catamenia.

In other places, notably on the Yukon, it goes otherwise; and when the phenomenon first occurs to one, she receives a severe scolding as though guilty of misbehavior.

If it is in winter a small space is curtained off from the remaining space by a piece of canvas or blanket; if in summer a tent is erected for her outside. This is the retreat chamber in which the young woman eats, sleeps, works, and muses. She is conducted to it by the oldest woman in the

camp, who also administers to her a mixture of water and oil extracted by boiling some salmon heads, which have undergone partial decomposition under water, and some dried slices of white fish. The grease is put in so she will always have grease in her mouth, which is equivalent to saying that she may always have food in abundance. Solemnly presented, the beverage is swallowed with equal solemnity. Then follows a sort of lecture in which the old woman presents herself as a pattern of all womanly virtues and inquires from the girl if she will conduct herself in the same praiseworthy manner. She, naturally, answers that she will. During the month of confinement, she cannot speak to any man; not even see his face, much less touch his clothes or any object belonging to him. No evil would ensue for her, but the misfortune would be all for him. When she has to leave the place for the necessities of nature, she must do so unseen. She generally goes out late at night after the others are in bed or early in the morning before they are awake. She wears a long parkie with a long hood. This hood is called the flabby cap, which is pulled over the eyes before leaving and kept down as long as she remains out. She is not allowed to undress, but sleeps with all her clothes on, even her mittens. In these, as well as in her stockings, she has some decayed birch wood, ground to a fine powder, that her hands and feet may remain dry throughout her lifetime.

The Eskimo values this circumstance because of the frequent occasions on which they are exposed, and which, in extremely cold weather, sometimes means freezing them. In her stocking she also wears next to the skin the horny soles cut off from the porcupine's feet that, during after life, her footwear may never wear out.

Around her waist she wears a cord, tying the drawers, on which are strung the heads of femurs of the porcupine. These are sawed off from the bone and perforated for the purpose, and a supply of them are always on hand. Besides this, she wears another porcupine cord of a peculiar nature. When a porcupine is killed and its bowels are taken out, they contain the feces in small round balls distributed along the intestine, and about three or four inches apart. The guts and contents are put to dry in this condition; and when a girl "goes apart" one of these strings is given to her. She sews it inside of a belt which she wears around her waist during the period of sequestration.

These cords are to enable her to bring forth children without difficulty. The porcupine of all animals known to the natives is the one that has the easiest parturition. It lays the young without effort, just momentarily interrupting its walk to deliver itself of them, and then resuming its motions as if nothing had happened.

The porcupine cords are intended to make the women porcupine-like in this important function. The Eskimos are convinced that they possess in this a great secret, and that the women of the white race suffer so much in labor because they do not know this.

To the same end, if during a woman's sequestration someone kills a female porcupine with young, the feti are given to the woman, who slips them within her shirt and makes them slide through down to her feet to obtain the porcupine facility of delivery. She is allowed no fresh meat during the whole month, except the flesh of porcupine.

Dried meat, fish, and marrow constitute her diet.

She cannot drink from the common cup, but has her own tableware and uses no other. She sucks water through a swan's bone, which is afterward tied around her neck. It serves, together with the parkie, to acquaint others of her condition.

A menstruating woman cannot sleep with her husband, more especially if he is young. She makes her bed apart from his, and both husband and wife sleep with their blankets over their heads that the effluvia of femininity may not pass from her to him and blast his manly abilities. After the flow is over she has to wash herself from what may remain. If, however, she should happen to be very busy, as during the salmon run, it is sufficient for her to wash her head very carefully.

The menses represent to the native mind the life-giving principle; hence, it is much used as a medicine.

The substance is at times obtained by washing in a basin of water rags soiled with it. The liquid is then used as a lotion to bathe young children or even administered to them as an internal remedy. Mothers believe that by so treating their children they preserve them from disease, although the reverse frequently happens.

I remember such a case at Mouse Point, a village on the Yukon; where a healthy child was made to drink some of this medicine and the following morning it was seized with an eruptive fever which, within twenty-four hours, had covered the whole body with red patches. Soon, however, the fever subsided and the patches turned into running sores, which did not heal for nearly a year.

In these would-be medical practices the mother always obtains the soiled rags from some other woman, never using her own, the idea appearing to be that the child has already received her entire stock of vital power; so she draws on others.

Now these people are quite faithful in their observance of these superstitions and others. Of course, individuals may disregard them at times, but they will never do so openly, and take care to persuade themselves and others as well that they are observing the customs even while acting against them. One may safely say that they tend to maintain a certain standard of morality.

When the savage is brought into contact with whites and begins to disregard these superstitions, unless something can be substituted the contact with our civilization invariably proves fatal to the race. I hope at some future time to take up other customs, especially those concerning pregnancy and childbirth.

CLINICAL NOTES AND CASE REPORTS

MULTIPLE NEUROFIBROMATOSIS*

By HARRY J. MAYER, M.D.
Los Angeles

AS contributions to the literature on von Recklinghausen's have multiplied, no longer is multiple neurofibromatosis, a fibroblastic diathesis with early optic nerve involvement, considered a rare disease. However, the case to be described is regarded as the earliest optic nerve involvement in neurofibromatosis to be recorded.

REPORT OF CASE

Mrs. Z. R., an American, aged 43, whose chief complaint, on admission to the out-patient department of Cedars of Lebanon Hospital in Los Angeles on January, 1935, was failing vision.

Past history showed treatment from 1925 to 1927 for pulmonary tuberculosis, and the surgical removal of, in 1918, the appendix; in 1926, one cystic ovary; in 1928, a small breast growth and tonsils; and in 1930, fibroid uterus and the other ovary. In May, 1931, radium was applied to a keloidal growth in the abdominal surgical scar. On August, 1931, a diagnosis of Dupuytren's contracture was considered in connection with a flexion of the right ring finger, to the flexor tendon of which adhered a firm nodule.

Important findings in the family history are: Father had a progressive loss of vision, beginning in his youth, becoming totally blind at the age of fifty-six. The paternal grandfather, who died at the age of eighty, had a growth with contraction of hand, his vision also being gradually lost.

On physical examination the patient showed a slightly generalized pigmentation of the skin. The pupil of the left eye was larger than that of the right eye, reacting more sluggishly to light. The visual acuity of the left eye was reduced to 20/200, that of the right eye to 20/50. The visual fields were found to be concentrically and markedly contracted, no fundus lesions being demonstrable. The deep reflexes were markedly exaggerated throughout. A soft subcutaneous nodule, two centimeters in diameter, was concealed at the scalp line behind the right ear; a smaller and much firmer nodule adhering to the flexor tendon of the right ring finger. Evidence of keloidal growth in abdominal surgical scar persisted.

The histopathologic diagnosis on biopsied nodule was neurofibromatosis.

Since 1930, laboratory findings, including blood Wassermann tests, studies on the cytology and chemistry of the blood, and three spinal fluid examinations, have been essentially negative.

Repeated roentgenologic examinations of the skull, cervical, dorsal, lumbosacral spine, thorax, shoulder, hand, gastro-intestinal and genito-urinary tracts, failed to disclose any pertinent anatomical change.

Treatment, which consisted of deep x-ray irradiation, resulted in temporary symptomatic and objective visual improvement.

COMMENT

Penfield's concept of von Recklinghausen's as a diffuse disease, with connective tissue proliferation in the nerve sheaths and the secondary formation of tumors, is illuminating.

Neoplastic connective or cicatricial tissue has the physical property of contracting upon ageing. The result in multiple neurofibromatosis is a pres-

* Read at staff meeting, Cedars of Lebanon Hospital, January 20, 1936.

sure atrophy of nerve fibers, with early loss of function.

A fibroblastic diathesis is apparent in this patient's family history, dermatologic manifestations, with confirmation in the histopathology of surgical specimens. Collectively, the findings described may be regarded in the light of a constitutional predisposition in which multiple neurofibromatosis is a disease entity.

1930 Wilshire Boulevard.

ANAPHYLAXIS FOLLOWING THE USE OF PITUITARY EXTRACT

By R. A. KOCHER, M.D.

Carmel

THE phenomena of protein sensitization, and of anaphylaxis resulting from a subsequent parenteral administration of the specific protein, have long been recognized. No case of anaphylactic reaction following the use of pituitary extract, so far as I am aware, has appeared in the literature. Since, therefore, I recently witnessed a severe reaction of this kind in a patient treated by hypodermic injections of United States Pharmacopeia solutions of pituitary, it seems worth while to report the experience.

REPORT OF CASE

B. K., a woman, aged 40, had had measles, chickenpox, and scarlet fever as a child. Infestation with *Entameba histolytica*, for a period of ten years, finally was completely cured six years ago with no demonstrable sequelae. Occasional mild attacks of influenza. Tonsillectomy in 1920. Otherwise, in good health. Physical examination revealed no pathology. Leads an active domestic life, has two children, ages four years, and five months, respectively. Both cesarean deliveries. The patient had never experienced an attack of urticaria, hay fever, asthma, or any other allergic condition. On May 18, 1936, she suffered an attack of herpes zoster, with four patches of cutaneous vesicles involving some of the endings of the lower branches of the right cervical plexus. There were no symptoms of any primary condition to account for the herpes, with the exception of fatigue as the result of a period of overactivity occasioned by the care of her two children. Encouraged by the favorable results reported in recent years in the use of pituitary extract for the treatment of herpes zoster by Sedlick in 1930,¹ Niles in 1932,² Somers and Pouppirt in 1935,³ and by personal previous experience in two cases, I decided on its use in the present case. Following the method described by Somers and Pouppirt, this patient was given an initial injection of 0.2 cubic centimeter of posterior pituitary extract (U. S. P. ampoule, Squibb). There was no unfavorable reaction; this was followed in one hour with 0.5 cubic centimeter. There was a fleeting pallor and tremor following the injection, and considerable relief of pain. This dose was repeated in three hours, and during the following two days, injections of 0.5 cubic centimeter as pain reappeared; the intervals varied from two to four hours. By the end of the third day a total of 5 cubic centimeters of surgical pituitrin had been given, the pain had greatly subsided and the vesicles had begun to dry up.

On the sixth day, following the last injection of pituitary, and at about 4 p. m. the patient noted the appearance of four or five urticarial wheals about one-half centimeter in diameter, with intense itching, on the flexor surface of both forearms. By 8 p. m. similar scattered wheals appeared on all parts of the trunk and extremities. At five o'clock the following morning I was called and found the patient in shock, covered from head to foot with scattered

giant urticarial wheals; the largest, on the buttocks at the site of the original injections, measured 5 to 10 centimeters in diameter. There were nausea and vomiting; pulse 140, thready; blood pressure, 80/50; temperature, 97 degrees Fahrenheit. There was slight chill; patient complained of pain in the joints, intense itching, and a feeling she was going to faint. She was immediately given a hypodermic injection of epinephrin, one cubic centimeter, to which she responded within a few minutes by relief of the nausea and vomiting; improvement in pulse, rate 100, fair volume; blood pressure, 110/70. The intense itching and burning of the urticaria were not much relieved by the epinephrin. Along with soothing lotions and starch baths, injections of epinephrin, 0.5 cubic centimeter, were given at intervals of three to four hours. Giant urticarial wheals appeared in fresh crops about every six to ten hours, preceded by nausea and vomiting, ultimately involving every square inch of the body surface, not missing the vulva, rectum, scalp, palms of hands, and soles of the feet. By the end of four days the urticaria began to abate, and within twelve more hours had entirely disappeared, leaving a slight edema of the face for an additional twenty-four hours.

COMMENT

At the time of delivery of her last baby five months previously, this patient had received repeated injections of posterior pituitary extract for the control of uterine contraction as well as gas pains. There is no doubt that these were the sensitizing doses of pituitary. Pituitary extract contains the water-soluble principles from the fresh posterior lobes of the pituitary body of cattle. Whether any precautions are taken in the preparation of this extract to exclude water-soluble proteins or their derivatives, I do not know. In any event, it seems most probable that accompanying proteins rather than the active pituitary principle are responsible for the sensitization and subsequent anaphylactic reaction described. It has been mentioned that this patient had never before experienced an allergic reaction of any kind. Furthermore, there is nothing in her recent history, habits or behavior to lead one to suspect any other substance than pituitary extract as the offending agent.

SUMMARY

A woman, age forty, otherwise in good health, was treated for herpes zoster by injections of posterior pituitary extract. Six days following the last injection of pituitary, she suffered an attack of anaphylactic shock, characterized by nausea, vomiting, fall in blood pressure, rapid, thready pulse, painful joints, and generalized giant urticaria. She was treated by injections of epinephrin and after four days of intense suffering made a complete recovery. Sensitization to pituitary (probably contaminating proteins) at time of childbirth, five months previously.

P. O. Box 926,

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2. Niles, H. D.: Herpes Zoster—Report of a Case of the Palm and Two Fingers, and Fifteen Other Cases Treated with Pituitrin, *New York State J. Med.*, Vol. 32, No. 13, p. 773, 1932.
3. Somers, Melvin R., and Pouppirt, Pearl S.: Herpes Zoster—Some of Its Clinical Aspects, *Calif. and West. Med.*, 42:370, 1935.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

PREPARATION OF CATHETERIZATION

I. PATHOLOGY AND DIAGNOSIS

EDWARD W. BEACH, M.D. (Medico-Dental Building, Sacramento).—*Historical Notes.*—Few surgical instruments boast the hoary antiquity of the lowly urethral catheter, and perhaps no single instrument has proved a greater boon generally nor afforded suffering mankind more relief. If we could but conjure a sort of retrospective television, or borrow Eric Bell's "Televisor" and thereby slip chronologically backward into possibly the fourth dynasty, we might behold our noble predecessor, old Imhotep himself, armed with a hollow metal instrument (not historically authenticated), bending over some unfortunate Egyptian in the throes of acute urinary retention. Somewhat later we could applaud the dexterity of the Hindu medico with his metal sonde (as related by Hessler) and follow the catheter's modification and development into the era of Hippocrates. Soon we might witness the advent of the non-metallic or flexible tube among the Arabs. Successively, as the centuries rolled swiftly by, we might study with amazement the bizarre types of catheters which made their appearance notably with the development of the lithotomy operation after the time of Ambroise Paré, and marvel at the unique materials, other than base metals, which were used to fabricate these early-day catheters. Then, if the modern aseptic conscience could withstand the shock, particularly anent catheter accessories and various embellishments, we might later watch with interest the importation of rubber into Europe, and see how quickly this new substance was adapted to the old principle of catheterization.

Taken all in all, it appears logical to assume that the procedure of catheterization must have antedated the Vedāngas, and yet it begins authentically, notwithstanding, in this period. Slowly at first, progress concerned itself with refinement of these pristine instruments as to form, size, shape, and contour, as well as intrinsic composition. With the dawn of aseptic comprehension, thanks to Pasteur and Lord Lister, the improvement in technique now came quickly to the fore. As a net result, today the physician possesses a wide assortment of catheters ranging in size, shape, composition, and structural design, which is sufficient to master almost any deviatory quotient, and the operation is performed aseptically. Indeed, the urethral catheter has now become as common and almost as indispensable to the profession as the carbon radical to the benzene series.

The invention of the first urethral catheter undoubtedly hinged upon the urgent necessity for relief. Even today the catheter still renders its

greatest service, and is most useful to the general profession as an emergency agent for relief of acute urinary retention. For the urologist, however, aside from this retention phase, the urethral catheter becomes a veritable factotum in the urologic domain, so wide and diversified is its application both as to treatment and diagnosis. Considered purely from the diagnostic standpoint, the catheter comprises a sort of ridgepole which offers support for the entire ensemble and about which much of the other urologic structure is draped. In fine, the catheter constitutes a virtual "runner-up" to the cystoscope, and offers the urologist an "open sesame" to the diagnostic realm, through which medium certain priceless information is educed which would be difficult or impossible to obtain in any other way. This diagnostic information may be gleaned directly from behavior of the catheter itself (*e. g.*, with urethral strictures), or indirectly with the catheter merely an intermediary agent for consummation of a definite objective (*e. g.*, the cystogram). Some of this diagnostic information possible of acquisition by means of the urethral catheter might be tabulated as follows:

(1) *Concerning the Urethra and Adnexa*

(a) Anent the penile, bulbous, and membranous portions of the urethra: The catheter may, at the outset, detect some urethral anomaly, *e. g.*, a diverticulum, etc. Again, strictures are common about the bulb (especially the venereal type), but these accrue, likewise, in the penile portion. The position, number, type, caliber of luminal diminution, and some idea as to the extent may all be roughly ascertained with the catheter. The catheter is particularly valuable in the "straddle" injury to determine the position, extent, and degree of urethral damage. This injury most often involves the membranous portion, and is usually incomplete, *i. e.*, catheterization is possible.

(b) Anent the pars prostatica: A stricture here, which is rare, usually means tuberculosis or lues. A general decrease in caliber may mean cancer. With prostatic hypertrophy, the prostatic urethra is usually lengthened and its anatomical conformation distorted, contingent upon the portion or portions of the prostate most implicated in the growth. In the precystoscopic era, for diagnostic purposes it was customary to measure accurately the length of the posterior urethra (the distance from the external sphincter to "water," which is normally about 4 centimeters) by calibrations upon the catheter. Any increase in length of this portion of the urethra was indicative of hypertrophy, and the degree of the latter commensurate with the former. An excellent idea of the prostatic lobe or lobes most involved in the

hypertrophy may be adduced from the urethral encroachment, or hence from the type of catheter (Nélaton, Wishard and stylet, Coudé, bicoudé, overcurve, etc.) which is necessary to treat of this architectural deviation and override the given impediment. With use of the catheter and radiopaque media, prostatic urethrography and a study of bladder-neck topography are easily managed. This procedure is particularly informative before and after transurethral resection, for comparison as to tissue removed, anatomical reconstruction, end-results, etc.

(2) Concerning the Bladder and Bladder Neck

(a) By means of the bladder urine: A catheterized specimen is often essential for diagnosis notably with regard to identification of the offending organism and for cultural study, not to mention determinations of the pus and erythrocytic content. The presence of residual urine is easily established with the catheter. Residual urine usually means vesical neck obstruction, but may connote nerve dysfunction or be indicative of diverticulum. Foul, ammoniacal residual urine suggests stone. A metal catheter may elicit the pathognomonic "click."

(b) By means of the bladder capacity: A bladder capacity under 150 cubic centimeters denotes contracture, while an increase above 600 cubic centimeter means bladder atony. Some idea of the bladder tone can also be acquired in this procedure by the force of the return flow from the urethral catheter. Prior to the development of the roentgen ray this capacity determination had great diagnostic value in suspected bladder rupture.

(c) By means of cystography: The catheter is essential to this procedure. Valuable diagnostic aid is furnished by this maneuver, especially in obstructive lesions about the vesical orifice, *e. g.*, posterior valves in children, contracted vesical neck in the middle-aged, and true prostatism in the aged, etc. Cystography is also of value in the diagnosis of vesical tumors and diverticuli, and especially by contrast pictures in the latter. Cystography is of the greatest importance in suspected vesical injuries, to confirm the presence of bladder rupture and to indicate the location.

(d) By means of the cystometer: The catheter is necessary in this procedure, which comprises a technical method for accurately measuring the intravesical pressure, with a specially constructed manometer (usually the Rose device). Several readings are taken at specific intervals and a graph constructed to be contrasted with the normal. This is the best method, to date, for differentiation of the usual myogenic atony of the bladder contingent upon pure obstructive phenomena from that type of bladder atony dependent solely upon nerve changes. Sometimes, however, these two conditions coexist with confusion of the picture. When defective enervation is present, the cystometer may also help to distinguish which of the three nerve groups, viz., pelvic, hypogastric and pudendal, is at fault. Much knowledge remains undiscovered in this field and most specifically as

to evaluation of sphincter tonus (both internal and external) in its relation to that of the detrusor.

From this brief outline, one immediately appreciates the exalted position which the ancient and lowly urethral catheter has come to assume in the sphere of modern urologic diagnosis.

* * *

II. TREATMENT

HENRY A. R. KREUTZMANN, M. D. (2000 Van Ness Avenue, San Francisco).—The various conditions in which catheter treatments are important are:

1. Retention due to (a) prostate abscess; (b) urethral stricture; (c) hypertrophied prostate.
2. Rupture of posterior urethra.
3. Cord injury.

There are many types and shapes of catheters. For general purposes, a No. 18F. or 20F. Robinson catheter is excellent. It is a soft rubber catheter with two eyes. The tip has a depression into which a stylet can be inserted without danger of it slipping out and perforating the urethra.

The most common catheter used in women is made of glass. There is always danger of its becoming cracked on boiling and breaking off after insertion. Another disadvantage is the fact that it will promptly fall out if not constantly held in place. The ideal catheter for women is the Furniss metal catheter. It is shaped to fit the female urethra and is self-retaining.

There are two types of retention catheters. They are the mushroom or Pezzar, and the winged or Malecot catheters. The latter are either two- or four-winged. The four-winged is the better, as there is less chance of its slipping out of the bladder. The retention catheters are used following cystostomy. They are not to be inserted through the male urethra.

In women the Malecot catheter is excellent for urethral drainage, as it produces less irritation *in situ* and its removal causes little discomfort.

Prostatic Abscess

Acute retention following prostatic abscess is nearly always a complication of an acute gonorrheal urethritis. Although instrumentation during a gonorrheal infection is contraindicated, these cases are an exception. A small coude woven catheter has the proper stiffness, and its tip has the proper angle to ride over the bulging prostate with a minimum of trauma and pain. It should be used in preference to either a soft rubber or metal catheter.

Urethral Stricture

Acute retention usually results from the complete closure of a strictured area following either an alcoholic or sexual debauch, or both. One may be assured that strictures in these men are severe, of long duration, and that treatment has been greatly neglected. It is inadvisable to attempt to open up the stricture with either sounds or metal catheters. There is great danger of producing false passages or of perforating the urethra.

Attempts to empty the bladder should be made with the smallest size (10F.) woven catheter with a coudé tip, or the smallest sizes (4-6F.) straight olive-tipped, woven catheters. Too much instrumentation with these catheters will do real damage, therefore one should not persist too long in attempting to pass them. It is better to insert threaded filiforms to which a woven Phillips urethral catheter, size 8-10F., is attached, after successfully passing one filiform through the strictured area.

Hypertrophied Prostate

The purpose of catheters in these cases is twofold:

1. To relieve acute retention.
2. To institute drainage preparatory to operation.

The first attempts to relieve acute retention in prostatics should be made with a small size (10 to 12F.) soft rubber catheter. If unsuccessful, either a woven coudé or bicoudé catheter should be tried. Metal catheters are contraindicated on these patients. When all other catheters have failed, a No. 6 olive-tipped ureteral catheter will often slip by the obstruction. A ureteral catheter is also very helpful in long-standing cases of obstruction where the bladder is greatly dilated, and sudden complete emptying may result in renal hemorrhage, shock, and even death. The small lumen of a ureteral catheter assures very slow emptying of the bladder, thereby preventing any of the complications just mentioned.

Preliminary drainage of the bladder with an indwelling catheter is an essential procedure in preparing patients for prostatectomy. Some urologists use a No. 18 or 20F. soft-rubber catheter tied in the urethra. In patients with a sensitive urethra this cannot be tolerated. There is also the possibility of epididymitis developing if the vasa are not first ligated. Therefore, many surgeons perform a two-stage prostatectomy, preferring to drain the bladder suprapubically with a Pezzar catheter.

If the bladder is greatly distended, one can pass a No. 20 Malecot catheter, stretched on a straight stylet, through a trocar which has been inserted into the bladder through the space of Retzius. A silkworm gut suture through the adjacent skin is tied about the catheter, thereby preventing its accidental removal. By this method there is no leakage of urine around the catheter, and the patient need not be hospitalized. This does away with a preliminary cystostomy, but should not be attempted where the bladder capacity is less than 500 cubic centimeters, as the trocar may perforate the bowel.

Rupture of Posterior Urethra

This condition usually results from an accident. Attempts should be made to pass a No. 22 to 24F. soft-rubber catheter. If the avulsion is not severe, the catheter will pass readily. If the catheter will not pass easily, stop all manipulations, as continued efforts will only increase the tear in the urethra.

It is better to open the bladder suprapubically and pass a catheter retrograde from the internal sphincter through the meatus. A soft-rubber catheter of the same size is tied to the tip of the one in the urethra. The catheters are then pulled out of the suprapubic wound until the openings of the second one are in the bladder. The two catheters are then cut apart and the bladder is closed around a Pezzar catheter. The urethral catheter is left *in situ* for two weeks or more, depending on the amount of urethra torn.

Cord Injury

Complete bladder retention resulting from injury to the cord is usually treated by intermittent catheterization. Sooner or later cystitis will develop, followed by pyelitis or pyelonephritis.

If the physician has the courage, he will refrain from any catheterization. For some time the bladder will be greatly distended with overflow incontinence. In time, however, automatic emptying of the bladder will result and urinary infection will not complicate the primary condition.

General Consideration

Physicians should at all times regard catheterization as an important surgical procedure. It should be performed only under proper aseptic conditions such as thorough cleansing of the meatus and the use of sterile towels, gloves, instruments, and lubricant.

In prostatitis and patients with urethral stricture, some urinary antiseptic should be given for several days beforehand.

Urethral chill is a frequent complication of catheterization. It can often be aborted by the oral administration of urinary antiseptics; by giving quinin every four hours for a short time before and after treatment, and by irrigating the urethra with an antiseptic solution before passing a catheter.

* * *

III. CATHETERIZATION OF THE FEMALE

ADOLPH A. KUTZMANN, M. D. (1930 Wilshire Boulevard, Los Angeles).—Catheterization of the female should be a simple procedure, but so complex has it been made with awkward and unnecessary preparations that it has become almost akin to a major operation in some institutions. This complex procedure is the result of two facts, the complicated standard technique as taught in training schools for nurses and the unnecessary preparation, almost bordering on fanaticism, demanded by many physicians to avoid supposed contamination, a presumed cause of cystitis.

Catheterization of the female is and should be kept a simple procedure. The extensive use of sterile towels covering the thighs, abdomen and bed, and excessive washing of the external genitalia pubes and vestibule are not necessary. The catheter, if it is of the proper type and skillfully handled, will never come in contact with these surfaces. The use of much cleansing fluid, such as green soap, 1-1000 mercury bichlorid solution, will leave the patient in a pool of contaminated

water, as well as a collection of unclean fluid in the posterior fourchette; exception to this may be in the case after vaginal surgery or during the puerperium. The use of the male soft-rubber catheter leads to awkward and painful catheterization. Consider the fact that the female urethra is about $1\frac{1}{2}$ inches long, semi-crescent in shape. If the long catheter is used it must be gathered in a sterile gloved hand or permitted to drag along. It should be passed about $1\frac{1}{2}$ to 2 inches, but it will not remain in place, slipping out because of the weight of the very long portion left outside. The natural reaction, therefore, is to keep pushing in such a catheter until about 4 to 6 inches are in the bladder. This will cause a loop to be formed against the bladder wall, resulting in pain. If an irrigation or instillation is to be given by the syringe method, such a kinked or looped catheter will tend to straighten out under the pressure, thereby enhancing the pain to the point of distress, and even trauma. Should the funnel gravity method be used, the fluid would probably not enter the bladder because of the kink in the catheter. To avoid this with the long, soft-rubber catheter, it must be constantly held in the proper place with one hand, thereby handicapping the skillful carrying out of the procedure when an instillation or an irrigation is to be given. The use of female catheters, 18 to 20 French in size, either glass, metal, or woven silk, with the proper shape and contour, will easily eliminate such troubles. The use of the short, stiff female catheter is always under complete control during the act of catheterization. The end of the catheter need never be touched by instrument nor hand, but directly passed into the bladder to the proper distance and without any difficulty. Because of their shape they will usually remain in the proper position of their own accord. The use of pyrex-glass catheters, and their careful examination prior to insertion, will avoid the chance of breaking. Should it be wished to eliminate this element of the danger of breaking, the metal or silk-woven catheter may be used. I believe that the danger of glass catheters breaking has been exaggerated. But one such case has been observed by the writer, and this was due to the permitting of an inexperienced student nurse to catheterize a pregnant woman, an obvious mistake.

The simple catheterization of a female may be carried out as follows: The patient is placed flat on her back, in the lithotomy position, either on a table or the bed. If the latter, the legs are pulled up and bent outward, thereby obtaining a position similar to the lithotomy. The attendant's hands should be thoroughly washed. If right-handed, stand to the right of the patient, if in bed. With the fingers of the left hand, the labia are spread apart so as to obtain a good view of the external urinary meatus. A good light should always be available. With the right hand, and using a good soft piece of cotton, dipped in a mild mercurial solution (1-1000 solution mercuric cyanid, merthiolate, oxycyanid of mercury or any other good mercurial solution), the vestibule is cleansed, washing from above downward, each time dis-

carding the used cotton. If it is necessary to let the labia fall back in place, a piece of cotton dipped in the cleansing solution is first placed in the vestibule. Then using a stiff female catheter (glass, metal, or woven silk), the cotton is removed and, again holding the labia apart, the catheter is inserted about two inches, utilizing gentle pressure and carefully following the urethral curve. Since the female catheters are shaped, they will usually remain in place without holding, permitting the use of both hands to carry out an irrigation or instillation. Keeping the procedure of catheterizing the female simple will, therefore, be less likely to result in a bladder infection. It is the traumatizing of the urethra and bladder, with the permitting of prolonged bladder distention or the overlooking of a urinary residual that really result in cystitis. Too often the nurse or house physician is unnecessarily blamed by the attending physician because of the lack of understanding this simple procedure of catheterization. Nothing predisposes to bladder infection as much as trauma, obstruction, residual, and distention. It is well-nigh impossible to infect a normal bladder, except possibly with the gonococcus.

Shortage of Radium.—The National Radium Trust was established in 1929 with a capital of \$1,250,000, contributed by the public to provide radium for the treatment of disease. The trust appointed a National Radium Commission to distribute the radium to hospitals and clinics. In the report for the year ended July 1936, just published, the Commission states that, in order to secure efficient radium service for the country it will be necessary for the present radium centers to extend their work, new centers will have to be formed, and further supplies of radium are required. At most of the centers there has been a tendency to replace the interstitial and intracavitary use of small quantities of radium by the application at a distance of large quantities of radium. This method has led to many of the centers pressing the Commission for more radium. The report records much progress at almost all the centers and high level of initiative and zeal, which will go far toward solving the grave problem of the Commission. The trend of present-day experience indicates the advantages in certain cases of cancer of combining radium and x-ray treatment. It is calculated that in this country about forty thousand persons are suffering from cancer in those accessible organs in which radium may be of value, but that only eight thousand obtain the treatment.—*A. M. A. London Correspondent.*

Elaborate Preparations Against Attacks with Poison Gas.—Britain will soon be the first country in the world to have gas masks available for the whole of the civil population of the capital. Scientific and technical experts have worked out a difficult and new problem: how to produce a simplified and improved gas mask, which can be made by the million by mass production methods. At a factory established by the government, the output will soon be half a million masks a week, and it is proposed to make thirty million, sufficient for the whole civilian population. The components of a gas mask are a light metal container filled with activated charcoal, several pieces of wire gauze, a thick wad of absorbent cotton, some layers of muslin fabric, metal springs, and a rubber mask or face piece into which the container is fixed. The mask fits securely under the chin, over the mouth, cheeks, and eyes. A cellulose acetate window permits vision. The mask is fixed to the head by easily fitting elastic straps.—*A. M. A. London Correspondent.*

Yet all experience is an arch where through
Gleams that untraveled world whose margin fades
Forever and forever when I move.

—Alfred Tennyson

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

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THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *Dues! Dues! Payable Before April First.*
2. *Specialty Examining Boards.*
3. *Ethics or Etiquette.*
4. *Del Monte Session, May 2-6.*
5. *Del Monte Meeting: Past Presidents Advance Reasons for Attendance.*
6. *Reduced Railroad Rates to Del Monte.*
7. *Medical Society of the State of California.*
8. *Why Insurance Premiums Are High.*
9. *North and South Golf Tournament in Del Monte.*
10. *Four Cents Per Day!*

DEPARTMENT OF PUBLIC RELATIONS

1. *Public Education.*
2. *"They Who Said It Couldn't Happen."*
3. *Annual Reports.*

ASSOCIATION ACTIVITIES

DUES! DUES! PAYABLE BEFORE APRIL FIRST

Unless your 1937 dues to your County and State Association are paid to your county secretary, this will be the last issue of this publication that you will receive while being in arrears.

The by-laws provide that members whose dues are not paid on April 1 shall be placed on the roll of delinquent members, the JOURNAL shall be discontinued, and all membership privileges and rights suspended.

Hence the query: Have you paid your 1937 dues? If not, *remit them today* to your county secretary and thereby remain in good membership standing.

These are serious days and times. Grave questions confront the profession as a whole and members individually. There are some three hundred bills before the present session of the Legislature that affect every individual practicing physician. United action and support is necessary to prevent undesirable, unwise, and harmful enactments. Your committee and officers are intensely active in guarding your personal and professional interests.

The least you can do is to remit your dues so as to benefit from this representation. Write that check today and see that it reaches your county secretary within twenty-four hours.

SPECIALTY EXAMINING BOARDS

The latest advice from the Council on Medical Education and Hospitals is that the following examining boards in the medical specialties have been fully approved by the Council: American Board of Dermatology and Syphilology; American Board of Obstetrics and Gynecology; American Board of Orthopedic Surgery; American Board of Pediatrics; American Board of Psychiatry and Neurology; American Board of Radiology; American Board of Urology; American Board of Internal Medicine.

* All articles listed under the caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

This action was authorized by the House of Delegates of the American Medical Association, which invested control of special examining boards and the formulation of standards to be met in this Council.

ETHICS OR ETIQUETTE

It is interesting to think of the relations between ethics and etiquette. The most satisfactory definition is: "The science of human duty." Etiquette is defined as usages of professional intercourse. Science of duty conveys the thought of authority and permanence. Usages of professional intercourse may vary at different times and places. Ethics is compelling, while etiquette is persuasive. They are so closely related that neither can be ignored in the practice of medicine without serious loss. The disregard of them is the occasion of many complaints, much bitter feeling, disrupted friendship, lifelong enmities, and even personal violence.

If the public fails to give the medical profession the degree of respect and confidence to which it is entitled, if the attitude of many intelligent and worthy people to us is one of criticism and distrust, if we fail to inspire sentiments of grateful appreciation, may it not be that we are responsible and that the cause lies in our disregard of professional ethics and etiquette?

The duty that a medical man owes to his profession has greater claims upon him than any other duty. None of us is above criticism, and we cannot expect to receive more courteous treatment than we accord to others.

It behooves us all to give considerable thought to the ethics and etiquette of our conduct as we pursue our vocation and come in contact with fellow men.

DEL MONTE SESSION, MAY 2-6

This issue has a supplement which contains the official program and Pre-Convention Bulletin for the Association's annual session in Del Monte, May 2-6.

Members are invited to carefully read the program and annual reports. The program is very creditable, and contains many interesting subjects that will be presented by capable guests and California clinicians. It is an educational, postgraduate series of papers, discussions, and scientific demonstrations. No member can lightly conclude that he cannot afford to attend or carelessly pass up this annual session. Members should embrace this opportunity for their personal and professional good.

Hotels.—Ample hotel accommodations, all within a few minutes from Hotel Del Monte, are and will be available. Write to Mr. Carl Stanley, Manager, Hotel Del Monte, Del Monte, California; tell him the accommodations you desire. Mr. Stanley is in charge of all hotel reservations in Monterey Peninsula, and will provide you with acceptable, comfortable hotel service. Better write today.

Determine to attend the Del Monte session. Reread the program supplement of this issue. Surely, you will feel the urge to attend.

OUR INVITED GUESTS

Our annual sessions have always been characterized by the presence of distinguished national clinicians who take prominent part in the scientific program. The array of distinguished guests for this year's annual session is indeed notable: William C. Woodward, Jesse G. M. Bullowa, Cyrus Cressey Sturgis, and Norman F. Miller.

Our Association is extremely favored this year in having outstanding guest speakers from without the State participate in our scientific program for the Del Monte

annual session. They are known well and favorably in our medical world. An extended biography or write-up of each guest is not indicated nor is it necessary. Consequently, only a brief statement is being made in regard to the professional background of each one of our invited guests.

W. C. Woodward, M.D. Doctor Woodward requires no introduction. Holding the degree of Doctor of Medicine and Bachelor of Law, he has most efficiently served the profession as director of the Bureau of Legal Medicine and Legislation of the American Medical Association. Sufficient credit cannot be given him for his conscientious and efficient services. Doctor Woodward will bring us the last word upon Social Security legislation and enactments both Federal and State. His address before the third general meeting will be of vital interest to every member.

Jesse G. M. Bullova, M.D., New York City. The following are personal data regarding this guest speaker. Born October 19, 1879, in New York City. A.B. at the College of the City of New York. M.D. at Columbia University, College of Physicians and Surgeons, 1903. Internship: Montefiore Hospital, Mount Sinai Hospital, Willard Parker Hospital, and Sloane Hospital for Women, all of New York. Teaching appointment: Clinical Professor of Medicine, New York University College of Medicine. Hospital appointments: Visiting physician, Harlem Hospital; visiting physician, Willard Parker Hospital; consulting physician, New York Infirmary for Women and Children; and consulting serologist, Long Beach Hospital.

Cyrus Cressey Sturgis, M.D. Born in Pendleton, Oregon, April 2, 1891. B.S., University of Washington in 1913; M.D., Johns Hopkins University in 1917. Medical house officer of Peter Bent Brigham Hospital, 1917-1918; First Lieutenant, Medical Corps, United States Army, 1918-1919; assistant resident physician, Peter Bent Brigham Hospital, 1919-1920; resident physician, Peter Bent Brigham Hospital, 1920-1922; teaching fellow in medicine, Harvard Medical School, 1920-1922; faculty instructor in medicine, Harvard Medical School, 1922-1925; associate physician, Collis P. Huntington Memorial Hospital, 1925-1926; assistant professor of medicine, Harvard Medical School, 1925-1927; physician, Peter Bent Brigham Hospital, 1925-1927.

Present positions: Professor of medicine, University of Michigan Medical School, director, Thomas Henry Simpson Memorial Institute for Medical Research; director, Department of Internal Medicine, University Hospital.

Society memberships: Association of American Physicians; American College of Physicians; American Society for Clinical Investigation; Central Society for Clinical Research; American Association for the Advancement of Science; American Clinical and Climatological Association; Washtenaw County, Michigan State, and American Medical Associations.

Doctor Sturgis will conduct the Clinical-Pathological conferences at the second general meeting, and will present a paper before the Section on General Medicine.

Norman F. Miller, M.D. Was graduated from the University of Michigan Medical School in 1920. From then until 1926 served as instructor and assistant professor in the Department of Obstetrics and Gynecology at the University of Michigan.

In 1926 became affiliated with the University of Iowa, where he served as associate and later as professor of obstetrics and gynecology. In 1931 returned to the University of Michigan as professor and head of the Department of Obstetrics and Gynecology.

Doctor Miller will present a paper at the first general meeting and before the Section on Obstetrics and Gynecology.

DEL MONTE MEETING: PAST PRESIDENTS ADVANCE REASONS FOR ATTENDANCE

Why attend annual sessions of the Association? Past presidents advance reasons why members should attend. If these are not sufficiently inducive, please refer to the supplement of this issue, note the speakers on the programs for scientific sections and general meetings and then ask yourself if you can afford to miss this opportunity of hearing the latest and practical in the medical world.

Ample hotel accommodations for all in first-class hotels in the Monterey area, five to fifteen minutes from the meeting places. Write today to Mr. Carl Stanley, Hotel Del Monte, Del Monte, California, who is in charge of all reservations, and ask him to assign you the accommodations you desire. But now read what our past presidents say. (Their replies are responses to a letter from the Association Secretary.)

FROM DR. JOHN C. KING: PRESIDENT IN 1909

I enclose copy as requested. Take my own medicine? Well, I am too deaf to hear the proceedings; too deaf to participate in conversation, even with the aid of my acousticon; too courteous to burden my friends with the annoyance of trying to make me hear. No complaint! At eighty-four one is entitled to some disability. Then, too, one gets lonely when old friends have departed. Of course, I have many among the younger set; young fellows like George Kress, Will Roblee, Joe King, Paul Ferrier, lots of others. But why bore them with my deafness? Hope you will have a rousing meeting and that will not be due to numbers alone.

* * *

We are selfish. Attendance pays. Professional success, financial and other, depends much on the support, respect and friendship of colleagues. State meetings afford opportunity to acquire one or more of these. "It is more blessed to give than to receive." Give a paper, discussion, appreciation, the friendliness of one's presence.

* * *

FROM GEORGE H. KRESS: PRESIDENT IN 1916

Annual sessions of our State Medical Association provide the environment in which, while renewing our allegiance to the guild of the healing art, we at the same time move forward, individually and collectively, in greater attainment of the scientific, fraternal, and organization objectives to which we have pledged our best efforts.

* * *

FROM JOHN H. GRAVES: PRESIDENT IN 1921

Reasons why members should attend the annual meeting:

1. More knowledge of recent progress in medicine and surgery can be gained in less time, with less effort than in any other way.

2. To preserve established friendships and create new ones.

3. To cooperate with colleagues in supporting measures that will protect the ideals of the profession and improve our service to the sick.

* * *

FROM EDWARD N. EWER: PRESIDENT IN 1925

The California Medical Association's annual meeting affords excellent opportunity to keep in touch with medical science progress. It is in constant movement.

Medical ethics, however, rest upon a foundation of right conduct among ourselves and in our public relations. There is little change in right and wrong. So go to the meeting and see if the officers and delegates you have elected are protecting this foundation against destructive termites from within and without.

* * *

FROM WILLIAM H. KIGER: PRESIDENT IN 1928

Would like to urge all members who possibly can to attend the annual meeting in Del Monte, for it is the best way to keep in touch with the activities of the Association. It is very vital during these troublesome times that the membership know what the State Association is trying to do for its members to help them solve many of their problems (professional and economic) that are confronting the profession.

* * *

FROM MORTON R. GIBBONS: PRESIDENT IN 1929

It seems to this writer that the advantages of attending California Medical Association conventions must be obvious. We must put first the opportunity to acquire new knowledge, hear men tell of their own work, and to discuss unsettled points.

A vacation, a few days relief from responsibility, especially with the consciousness that the patients at home

will grant such leave more readily than one for pleasure alone.

Renewal of friendships and improving of acquaintance-ship is pleasant and inspiring.

And not the least, the wives of the members have a very good time in a very agreeable environment.

* * *

FROM LYELL CARY KINNEY: PRESIDENT IN 1930

There are two reasons why we should go to Del Monte.

First: This is the yearly opportunity offered by the State Medical Society for reeducation, to keep abreast with medical progress and to find inspiration for doing better medicine.

Second: Violent changes in medical practice threaten us in California. We should be with our delegates while they are considering these problems so that they may know and follow the wishes of the entire membership in their decision.

* * *

FROM JOSEPH M. KING: PRESIDENT IN 1932

I regret that I have been so busy since receiving your letter of February 20 that I have not had the time to formulate a worth while fifty-word statement as you request, but there are many of the other past presidents so much more gifted in this sort of thing than am I that you doubtless will have all the copy you will need.

I shall be at the past presidents' breakfast Tuesday morning if I arise early enough; rather doubtful, in view of the fact that there are no single accommodations available in the convention hotel. I am, it seems, to put it mildly, a rather vigorous snorer, and so I do not inflict my infirmity on others.

* * *

FROM C. G. TOLAND: PRESIDENT IN 1934

It is very necessary that all members of the California Medical Association make a real effort to attend the meeting at Del Monte in May, 1937.

The officers, councilors, and chairmen of the standing committees feel that this is an opportunity for you to hear of the activities of the Society and to express, through your delegates or personally, your opinion on important matters that will be discussed. A great deal of hard work has been done, especially by our Legislative Committee, the results of which you should hear first-hand.

FROM ROBERT A. PEERS: PRESIDENT IN 1935

I am just in receipt of your letter of February 20, and I am enclosing herewith a short statement for the April JOURNAL.

✓ ✓ ✓

"Iron sharpeneth iron; so a man sharpeneth the countenance of his friend."—Proverbs 27:17.

Contact between medical men at our annual meetings sharpens the intelligence, promotes increased enthusiasm, and sends the participants home prepared to practice better medicine. It also makes for better fellowship. Be sure to attend the Del Monte meeting.

REDUCED RAILROAD RATES TO DEL MONTE

Arrangements have been made whereby members traveling by train may secure reduced rates on railroad tickets to Del Monte.

To secure this reduction a certificate must be presented to the agent at the time when the ticket is purchased.

Members can obtain these certificates by sending a *self-addressed stamped* envelope and request to the Association's headquarters, 450 Sutter Street, San Francisco.

MEDICAL SOCIETY OF THE STATE OF CALIFORNIA Notice to Members

The annual meeting of the Medical Society of the State of California will be held in Hotel Del Monte, Del Monte, California, at 4:15 p. m. on Wednesday, May 5. Meeting room will be announced on the bulletin board.

All members are urged to attend. Annual reports will be rendered and important matters considered.

F. C. WARSHUIS, *Secretary*.

WHY INSURANCE PREMIUMS ARE HIGH

Case 1: "Had I seen the eye one day earlier I could have saved it." *Sic*.

Case 2: "It was poor technique and not good practice."

Case 3: "Unlicensed physician was allowed to administer light and heat therapy in a doctor's office during illness of the doctor; result, severe burns."

The remark and opinion in Case 1 caused a \$50,000 damage suit to be filed against a very competent physician. The testimony of one physician in this suit caused a nineteen-day trial, a jury disagreement, attorney fees for the defense over \$3,000, and another trial yet to be defended. Carelessness in Case 3 in entrusting the patient's treatment to an unlicensed *locum tenens* agent has caused a suit for heavy damages. These cases occurred quite recently.

Suits, large verdicts, and expensive court procedures, in many instances due to unwarranted opinions, unsubstantial testimony, failure to employ due care, failure to call consultants, neglect in not obtaining x-rays, poorly kept records, and careless comments and opinions, cause malpractice suits and high premium rates for indemnity insurance.

You may not be a defendant today, but you are liable to be tomorrow. That liability will increase as long as physicians neglect to protect themselves against carelessness; as long as physicians will express unfounded opinions and give unwarranted testimony in favor of a plaintiff who seeks to make capital out of fabricated circumstances, and just so long insurance premiums will be exorbitant. When will medical men learn?

NORTH AND SOUTH GOLF TOURNAMENT IN DEL MONTE

This annual tournament will be revived in Del Monte on Sunday, May 2. Entries should be sent to Doctor Morgan, who issues the following declaration:

Dr. Robert W. Langley,
Los Angeles, Calif.

Dear Doctor:

We hereby issue a challenge to the Southern California Medical Golf Association for a North vs. South golf match to be played at Del Monte beginning at 12 noon on Sunday, May 2, 1937, the first day of the State meeting.

The State tournament is on Tuesday afternoon, but we cannot wait that long for a shot at the South. I trust that you remember that we have in our possession the trophy (the beautiful North-South plaque) which we won at our last meeting at Santa Barbara.

In order to give you some chance of winning and to show our charitable intent, we shall permit you to play any doctor whether he belongs to your association or not. We shall even permit you to play refugees from the flood and drought areas.

Daring you to reply and hoping that all of your scratch players develop dermatitis, I am

Medically yours,

JAMES W. MORGAN,
Secretary, Northern California Medical Golf Association.

FOUR CENTS PER DAY!

Under the initials of "L. D. R." the Westchester, New York, Medical Bulletin publishes these figures.

If you read a morning and evening paper, this costs \$30.10 per year.

If you smoke two ten-cent cigars a day, you spend \$73 per year. Five packs of cigarettes per week cost \$39 per year.

Your automobile insurance ranges from \$90 to \$160 per year.

If you indulge in a snack of Camembert and crackers before going to bed five nights a week, your revelry may reach \$35 per year.

To these we would add:

One cocktail before dinner daily.....	\$ 36.50
One highball (good stock) daily.....	54.75
And add one for wife or guests.....	164.25
Shaving cream (scented) and lotion.....	15.00
Chewing gum, two packs per week.....	5.65
Mints, two rolls per week.....	5.65
Two golf balls per week.....	78.00
One movie per week (self).....	31.20

Why figure further. The point is that we all exceed these expenditures, think nothing of it, and yet we do like to "rant and holler" about medical society dues. Use fifty-cent golf balls and cuss them as you play, but you will save sufficient on this one item to pay your county and state dues, without need for further holler. Your loss or winnings at the noon-hour bridge game will more than pay your annual medical dues.

Oh heck! Why figure or comment further? Incidentally, your dues were payable April 1 to avoid loss of membership. Have you sent your check to your county secretary?

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Public Education

In outlining suggestions for activities that will bring about better understanding on the part of all peoples our thoughts are of that wider province of the physician that lies beyond the laboratory, the hospital, and the consultation room—the education of the public at large.

DeWitt Clinton Poole, discussing propaganda, observes: "Scientific propaganda has invaded every strata of society and government. It no longer constitutes a curiosity, but instead has caused a feeling of alarm on the part of those who think with honesty of purpose as to the future welfare of society. These thinkers have noted the influence that is being exerted by minority high-pressure groups, organized and vocal, because of their effectual use of propaganda." To which thought we add propaganda for selfish ends.

Public health education movements cannot be classified as propaganda. The ends sought are not selfish or for personal gains for a minority group. Their purposes are the enhancement and conservation of the health of all peoples and all classes for the good of all society and government.

To educate the public so that it may reap the benefits of better health and physical well-being is not the sole responsibility of the medical profession. It is a joint responsibility to be assumed by the public, its representatives, and the members of the medical profession. By means of joint effort this responsibility can be discharged. It appears, however, that the initiative must be assumed by the medical profession.

For a number of years, medical organizations have sought in a more or less orderly and sometimes disorderly manner to undertake that initiative. Much has been accomplished, but much still remains to be done to enable the public to ascertain the possibilities of life.

"The perfection of communications—press and radio—has stimulated an interest on the part of perceiving, but not necessarily an intelligent and discretionary mankind in social relations and life. They are commencing to look up and beyond their immediate environment." They are beginning to see others and are comparing standards of living. Envy is creating demand, but again, the demands are not intelligent or based upon sound principles and facts. Education as to accepted principles and facts is the need of these days. To accomplish this the physician must assume an active rôle beyond that of his professional work, as stated in the opening paragraph.

What are the desirable educational means. At this time they can only be enumerated; specific details will be forthcoming:

1. Public lectures on health and scientific medicine before lay groups, Farm Bureaus, Parent-Teacher Associations, women's clubs, luncheon clubs, etc.

2. Public health hours in physicians' offices for preventive medicine and diagnostic physical examinations for those who are unable to assume the regular financial costs.

3. Radio broadcasts.

4. Personal education of patients by the attending physician.

5. Literature and texts in public libraries.

6. Public Health Institutes.

7. Sound local and State legislation, through education of local and State officials and legislators by members of county medical societies.

8. Interest in civic affairs.

As Poole also states: "Ever-widening millions are being raised from the politically negative condition into dynamic political units. It is not merely in an engineering sense that we are passing into a higher and higher-powered age. The dynamics of political action are being intensified in at least the ratio of our concomitant technologic advancement. Society is growing volatile and explosive to a degree we may not yet fully appreciate. Rightly directed the new forces can carry us into an empyrean of universal well-being and contentment. Misdirected, perverted by selfish or unenlightened leadership, it can lure us suddenly into the abyss."

The responsibility of education and right direction must be brought about by the initiative of the medical profession acting through the individual doctor. Is this being recognized by you and your county medical society? If not, will you, member, initiate the program of your county society to educate your public as to sound policies relating to medical care?

"They Who Said It Couldn't Happen"

A negro sought a lawyer to obtain a divorce, and the following conversation ensued:

"That woman talks too much—she just talks, talks, talks all the time and I can't stand it no longer."

"Well, what does she talk about?"

"Why, she doan say."

For a score of years there has been talk, talk and writing, writing upon the one subject variably designated as state medicine, health insurance, medical service plans, panel systems, governmental medical care, and social security. During the past few years the subject has been considered under the somewhat vague term of "medico-economics."

By means of resolutions, surveys, formulation of principles, and attitudes, the quest has been to assure ourselves that "it couldn't happen." Talk, talk, sporadic outbursts, and even condemnations of groups and individuals, temporarily afforded a flimsy sense of security. There was generated a sense of certainty that medicine and its disciples would be able to resist outside or governmental invasion into our ranks and insure the continuation of the conditions under which medical care was being provided.

But—"it has happened." As has recently been said: "Whether you like it or not, Social Security plans are here to stay." "Our only course open now is to coöperate and seek to shape and guide as best we can."

The cry is commencing to be heard: "Why didn't someone foresee this?" "Why were we not prepared?" "Where did we lack in foresight?" "Why was this not foretold?" "Little do we remember that the basic and only absolute certainty is the uncertainty of the future. Of one thing only can we be sure—that we cannot foretell the order of events, or whether or not they will occur."

"Foresight is not foreseeing, but the effective adjustment of conduct by matching probabilities against significant possibilities. Usually the possibilities that are significant to us are not those that we know *will* happen, but those that *have* happened; and the probabilities that we hope or fear will be realized are those that have been experienced in the past. Our sense of both the possibilities and the probabilities is largely a derivation of the past. It is not foresight, but projected hindsight." One need but review the yesterdays and their events to confirm this statement and obtain the answer as to why it *did* happen while there were those who said "it couldn't happen."

Now the query arises as to what problems the new program will create. Somebody has got to solve these problems. How?

Surely, we all hope that they will be solved by the application to the new conditions of the old principles of

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuls is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuls, Room 2004, Four Fifty Sutter Street, San Francisco.

justice out of which grew our institutions; but to do that we must understand those principles, their history, their spirit, their capacity for extension and their right application. Upon this principle your Council and committees are earnestly engaged in developing and creating a program and policy for our members. This policy and program is being transmitted to county society officers for presentation to the members of their organizations. The request is made that every member become conversant with their provisions and conform to their application. "Whether you like it or not" is repeated because unless there is manifested a full coöperation attitude, each non-coöperating member is bound to lessen the possibility of acquiring satisfactory adjustments and conditions in the social security program of government.

Remember, "It can happen." By cohesive unity untoward, undesirable happenings may be minimized. Cease talking. Act!

Annual Reports

This issue contains the annual report of the Committee on Public Relations as well as the reports of other standing committees that are concerned with public affairs and relations. Members should read all of these reports. To not trespass too greatly upon your reading time, the articles in this department are being limited. Read the Pre-Convention Bulletin and program contained in the Supplement.

Committee on Public Relations

A meeting of the Committee on Public Relations was held in San Francisco, February 27, 1937.

1. Present: Chairman C. A. Dukes, M. R. Gibbons, F. B. Clarke, J. B. Harris, D. Crosby, Howard Morrow, Hartley Peart, Howard Hassard, F. C. Warnshuis, Louis Packard, and T. Henshaw Kelly.

2. *Resettlement Administration.*—The Director reported upon his interview with the Regional Director of the Federal Resettlement Administration. The Administration is desirous of establishing a policy for medical service for the clients of the Administration. A conference is to be held in Los Angeles on March 2 relative to seven-teen family State projects.

Pending further action by the Council and the House of Delegates, the Director was instructed, on motion of Dan Crosby, seconded by J. B. Harris, to recommend that the Administration set up a budget for medical care for each resettlement region and that there be free choice of physicians. That arrangements be made to pay for medical services on a fee schedule similar to the Los Angeles Water Department employees or the San Fernando plan under the supervision of the County Medical Society, and thus provide for the direct payment of the physician.

3. The annual report of the committee was approved. The Director was instructed to attach Dr. Lyell Kinney's report as an appendix. Upon motion of M. R. Gibbons, seconded by J. B. Harris, the Chairman was directed to present a suitable gift of appreciation to Doctor Kinney during the Del Monte session.

4. The Director reported upon his conference with the Chief of the License Division of the State Highway Traffic Department relative to physical standards to be met by automobile drivers applying for license. The State Division requests appointment of a committee to recommend these standards and to act in a medical advisory capacity.

On motion of M. R. Gibbons, seconded by Dan Crosby, the Chairman and the Director were authorized to appoint this committee.

5. *Speakers' Bureau.*—The Director recommended that a speakers' bureau be created. The Director reported upon weekly requests being received from lay organizations for medical speakers. He cited the Los Angeles Speakers' Bureau. He stated that he had filled some of these requests personally and had after much difficulty been able to secure members to fill these engagements.

On motion of Dan Crosby, seconded by J. B. Harris, the Director was instructed to take steps to address a special letter to county societies requesting them to formulate speakers' bureaus and to create an Association Central Speakers' Bureau.

Doctors Dan Crosby and T. Henshaw Kelly suggested that it was highly important that a corps of fifteen to twenty-five well-informed members be enlisted upon legislation and other important pending questions that are of public concern.

On motion of Dan Crosby, seconded by Fred B. Clarke, the Director was authorized to pay from the Committee's budget fund the expenses of speakers who requested reimbursement where engagements required hotel or extraordinary travel expense.

6. *Venereal Disease Educational Movement.*—The Director indicated the need and desirability of formulating a sustained program of public education on venereal disease and coöperation with the Special Committee of the State Association, of which Doctor Morrow is chairman.

Upon motion of Dan Crosby, seconded by J. B. Harris, the Chairman was authorized to appoint a special subcommittee to confer with Doctor Morrow's committee, to outline a plan, to prepare publicity items, and to report at the next meeting.

The Chairman appointed Dan Crosby, J. H. Graves, and Fred B. Clarke on such committee.

7. *Cancer Campaign.*—The Chairman called attention to the public cancer education campaign to be held in March. On motion of M. R. Gibbons, seconded by F. B. Clarke, the Committee recommended the coöperation of county societies.

Adjourned, to meet in Del Monte.

C. A. DUKES, *Chairman.*

F. C. WARNSHUIS, *Director.*

COMPONENT COUNTY MEDICAL SOCIETIES

HUMBOLDT COUNTY

The Humboldt County Medical Society met on the evening of March 4 at the General Hospital, with President Allan R. Watson presiding. Twenty members were present, and two guests—Doctors Matthew Hosmer and Howard Brown of San Francisco.

The Legislative Committee, headed by Doctor Norman, reported that they were active and ready to carry out any instructions that may come to their attention, of any new legislation.

Doctor Hosmer presented a paper on *Neuralgias and Pains From Ear, Nose, and Throat Conditions*. Doctor Brown discussed *Neuralgias and Pains From a Neurologist's Side of the Question*.

These papers were very much enjoyed, and all present voted it one of our best meetings.

LAWRENCE A. WING, *Secretary.*

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SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Raymond Wallerius, on February 16 at the Auditorium on Twenty-ninth and L streets. There were seventy-seven members and guests present.

The speaker of the evening, Dr. Eugene S. Kilgore, Professor of Medicine at the University of California, gave a very interesting and informative talk on *Coronary Occlusion: Its Symptoms, Diagnosis, and Treatment*. The differential diagnosis between real anginal pain and false anginal pain was first discussed in some detail by Doctor Kilgore. The subject of coronary occlusion and thrombosis was then presented, with special emphasis being placed upon some of the newer ideas in treatment, *i. e.*, use of the oxygen tent early in the attack; the use of small doses of quinidin, to prevent further attacks; and vasodilator drugs during the acute attack. Discussion by Doctors Gundrum, O. Johnson, Scatena, Reardan, and Pulford.

Dr. J. B. Harris, Chairman of the Legislative Committee of the California Medical Association, gave an interesting *preview* on the present legislature, stating that there are 3,897 bills in at present, 7 per cent of which (260 bills) concern the medical profession. Thirty-three bills pertain to the Medical Practice Act.

The application of Dr. E. R. Cole for transfer from the Fresno County Society was read for the first time.

The minutes of the last Board of Directors meeting were read and approved. Doctor Harris suggested that the two resolutions presented be sent to the Council of the California Medical Association for approval.

Doctor Scatena reported that the Banquet Committee was doing splendidly, and that the banquet would be held at the Sutter Club. A good program was assured by the committee.

GLENN E. MILLAR, *Secretary*.

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SAN DIEGO COUNTY

The San Diego County Medical Society begs to report the following news items:

February 9—Dr. S. J. McClendon, Society President, presented Dr. J. B. DeLee, who was guest speaker to perhaps the largest gathering ever attending our monthly medical dinners. Past presidents of the San Diego County Medical Society were special guests of honor. Doctor De Lee's subject, *Fetal Birth Injuries*, was well received. February 9 was also Ladies' Night.

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February 23—San Diego Galen Club, Dr. Paul E. Wedgewood, President, presented a symposium on *Chest Disturbances*. Doctors M. J. Hogan and R. A. Schneiders read papers. Dr. R. H. Sundberg presided as chairman.

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March 1—The Society met at a special dinner, honoring Dr. Walter Schiller of Vienna, Austria. Doctor Schiller's discourse dealt with *Endocrinological Aspects as Related to Gynecology*.

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Dr. W. H. Geistweit was reappointed to the California Board of Medical Examiners.

F. E. TOOMEY.

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SANTA BARBARA COUNTY

The regular meeting of the Santa Barbara County Medical Society was held in the Bissell Auditorium, Monday evening, March 8.

The secretary read a communication from the Police and Fire Commission, in which they asked for the names of members who would be willing to conduct sobriety tests at the police station. A panel of three will be selected for a six months' service at \$25 per month each.

Doctor Johnson introduced the speaker of the evening, Dr. John McKenzie Brown of Los Angeles, who gave an extremely interesting, instructive, and timely talk upon *Simusitis in Children*.

The paper was discussed by Dr. Pierre Voile of Los Angeles and Doctors Profant, Johnston, Lamb, Howard Eder, Hunt, Henderson, Means, and Mellinger.

The meeting was well attended and greatly enjoyed by all.

Doctor Jones of the Santa Maria branch asked the secretary to notify the membership that their branch wished to have the regular May meeting at Santa Maria under their auspices, promising their usual enjoyable time.

WILLIAM H. EATON, *Secretary*.

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VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Tuesday, March 9.

A report of the second annual Secretaries' Conference was given by the secretary. It was moved by Doctor Osborn, seconded by Doctor Shore, that the secretary be commended for the completeness and clarity of the report. Carried.

A plan of ethical advertising as a society was presented by Mr. Dunnigan of the *Ventura Star*. In the discussion following, the members present were favorable to the idea, but felt that it should be carried on in the various newspapers of the county, rather than in just a single newspaper. Doctor Hendricks appointed Doctor Shore to investigate the cost of advertising in the various newspapers throughout the county and suggest a plan for carrying on the campaign.

It was moved by Doctor Strong, seconded by Doctor Osborn, that the secretary be instructed to write a letter to the members who were not present at the meeting, outlining the plan and asking for a definite expression of an opinion from them. Carried.

It was moved by Doctor Neilsen, seconded by Doctor Bardill, and unanimously carried, that Dr. Thomas W. Hagerty be accepted as a member of the Society.

The meeting was then turned over to Doctor Shore, the program chairman, who introduced Doctors Moore, Walker, Wells, and Witten of the County Hospital. They presented a *Symposium on Gynecologic Cases From the County Hospital for the Past Year*.

A. A. MORRISON, *Secretary*.

CHANGES IN MEMBERSHIP

New Members (52)

Alameda County.—John James Hayes, Harold E. Roe.

Butte County.—Myrtle A. Cummings, C. E. Plumb.

Contra Costa County.—James Alison Cary.

Fresno County.—George T. Hoskins, George W. Olson, Madge Peirsol, Eliot Sorsky, K. L. Stout.

Kern County.—J. M. Krevitt.

Kings County.—E. C. Bond, P. K. Edmunds, Charles T. Rosson, Jr.

Los Angeles County.—Charles A. Bailey, Elmer J. Ball, Leon P. Belous, Ralph W. E. Bledsoe, F. Earl Brown, Stanley S. Bruechert, Willard T. Conley, H. C. Crumrine, William G. Durnin, Vincent P. Flynn, J. Edison Goldsmith, Ralph R. Greenspoon, John Hromadka, Abraham Marians, Tesla Nicola, Fenn E. Poole, Samuel Reznick, Lawrence A. Schueler, Samuel Shore, Bernard Silver.

Mendocino-Lake County.—F. J. Morley.

Merced County.—Raffaele Moretti.

San Diego County.—Bert A. Dannenberg.

San Francisco County.—Edward Campion, George C. Esker, Jr., Jean S. Feldheim, Webb Haymaker, Jay Jacobs, Jess P. Jacobson, E. Horace Klabunde, Leon M. Michels, Bernard Strauss, Jesse H. West.

San Mateo County.—Gordon Morrison, Milton F. Novotny, Phillip Seeley.

Tulare County.—F. Lynn Smith.

Ventura County.—Alexander W. Cruden.

Transferred (8)

John H. Childrey, from Santa Barbara County to San Mateo County.

Edwin R. Cole, from Fresno County to Sacramento County.

Fritz Held, from Orange County to San Bernardino County.

Elliott P. Smart, from Los Angeles County to San Joaquin County.

Frank P. Topping, from Sacramento County to Monterey County.

Paul A. Werthmann, from Merced County to San Joaquin County.

F. W. Yocum, from San Luis Obispo County to Stanislaus County.

Resigned (1)

Coleman A. Block, from San Francisco County.

In Memoriam

Busby, James Leslie. Died at Pasadena, February 23 1937, age 46. Graduate of the Ohio State University College of Medicine, Columbus, Ohio, 1913. Licensed in California in 1929. Doctor Busby was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

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Tomlinson, Richard Frank. Died at San Francisco, March 13, 1937, age 64. Graduate of Hahnemann Medical College of the Pacific, San Francisco, 1900, and licensed in California the same year. Doctor Tomlinson was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

Del Monte Annual Session

The convention in Del Monte is the thought uppermost in the minds of many of the Auxiliary members, and they will be pleased to learn that our national president, Mrs. Fitzgerald, intends to be present at that time. The convention will be held the first week in May, and much thought has been given all details by Mrs. John Hunt Shepard, who is the convention chairman. Monterey and Santa Clara auxiliaries are assisting her in every way. The convention program is published elsewhere in this JOURNAL.

It is with great regret that Mrs. Weil tendered her resignation as president-elect, but unavoidable circumstances caused her to change her plans. The Auxiliary is very fortunate in having Mrs. Hobart Rogers accept the vacant position. She has been recording secretary, and is familiar with the work of the organization and is most capable to discharge the duties of president. Let us all give her our support and help to make her administration a success.

The April edition of *The Courier* will be mailed to each Auxiliary member during the first week in April or earlier. If anyone does not receive a copy, please notify me or Mrs. Harry O. Hund, 400 Grand Avenue, San Rafael, and a copy will be sent at once.

MRS. ROBERT M. FURLONG,
State Publicity Chairman.

News Letter

Dear Auxiliary Members:

The question is often asked, "How can we interest more doctors' wives in our organization?" And my answer is, "Do not spend too much time trying to sell an idea to an quality of personnel that makes any organization succumb. The majority of people have fixed ideas by the time they are twenty-five or thirty. It is not quantity, but quality of personnel that makes any organization successful."

Never forget that we are auxiliary and our only purpose for organization is to serve the profession to which our husbands belong. Keep in mind also that our National Auxiliary has adopted certain policies and that if we work together as a national unit we can achieve more for the profession in a large sense than by concentrating all of our strength on local activities.

Men cannot rise to their highest and best capabilities unless their wives, too, possess the idealism of their profession. Yes, the wives of doctors need training also—training in character, training in intellectual poise, and training to live this rôle of doctor's wife.

MRS. DAVID S. LONG,
First Vice-President, National Auxiliary.

Component Auxiliaries

Alameda County

The Woman's Auxiliary to the Alameda County Medical Association held a special luncheon on February 12 at the Claremont Country Club, honoring Mrs. Andrew J. Thornton, State President, and Mrs. Willard H. Newman, State Corresponding Secretary.

Before the luncheon a reception was held for the one hundred members and guests assembled. The tables were gay with spring flowers, which had been arranged by the general chairman for the afternoon, Mrs. A. A. Alexander and her committee.

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Robert M. Furlong, Chairman of the Publicity and Publications Committee, Linden Lane, San Rafael. Brief reports of county auxiliary meetings will be welcomed by Mrs. Furlong and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

Following the luncheon, Mrs. Clarence Page introduced the honored guests, as well as the local members of the State Board, Mesdames Hobart Rogers, Charles Hall, and Frank Makinson.

After a brief business meeting Mrs. Thornton gave a splendid talk, giving highlights of other auxiliaries of the State, and complimenting the Alameda County Auxiliary on their Public Health Institute held in 1935. She emphasized the need of increasing Auxiliary membership through the influence of the individual member, and asked that the need of forming auxiliaries among unorganized counties be stressed when the opportunity arose at the coming State convention. Influence could also be used among laymen to correct and guide opinions where public health matters are concerned, and unlimited opportunities to serve are to be found when important legislation is pending.

The afternoon concluded with a delightful musical program—a trio of violin, piano, and cello—played by Mesdames Milton Shutes, Beau Mark Palmer, and Herbert Stoltz, all Auxiliary members. They played a Mendelssohn trio for an opening number, and "Moment Musicales" by Schubert as an encore. MRS. JOHN O'HANNESON,
Publicity Chairman.

Los Angeles County

The Woman's Auxiliary to the Los Angeles County Medical Association met on Tuesday, February 23, at the Pacific Coast Club in Long Beach, with 123 members present. President Mrs. Clifford A. Wright presided.

The luncheon tables were bright with red, white, and blue decorations, arranged by the Long Beach committee.

Honor guests were the wives of Navy doctors. The only speaker was Mr. Ben Read, who discussed pending legislative measures in which the medical profession is interested.

Immediately after lunch the group was conveyed to San Pedro, and from there in waiting water taxis to the U. S. S. *Relief*, hospital ship of the Navy. This was an unusual treat to all the members, and much credit is due the Long Beach committee, headed by Mrs. F. B. Settle, who arranged it. MRS. ROBERT L. CARROLL.

Marin County

Mrs. Andrew J. Thornton of San Diego, State President of the Woman's Auxiliary to the California Medical Association, and Mrs. Willard H. Newman, also of San Diego, who is State Secretary, were honored guests at the luncheon and meeting of the Woman's Auxiliary to the Marin County Medical Society at the Meadow Club on February 11.

Mrs. Harry O. Hund, President of the Marin Auxiliary, entertained the two distinguished visitors at dinner at her home on Grand Avenue.

Mrs. Thornton spoke on the work of the Auxiliary and its plans. A musical program was presented by the Marin Junior College Octet, under the direction of Clinton Lewis.

Santa Clara County

The February 8 meeting was a luncheon, held at the San Jose Country Club, forty-two members being present. Honored guests and speakers were: Mrs. Andrew J. Thornton, State President, and Mrs. Willard H. Newman, State Corresponding Secretary of San Diego. Mrs. Thornton painted a verbal picture of the history and organization of the medical auxiliaries and stressed the importance of a well-functioning social and educational group.

A letter was read from the American Association of University Women, inviting members of the Auxiliary to hear Dr. Leo Eloesser of San Francisco, recently returned from a three months' stay in Russia, speak on *Medical Education, Care and Organization in the Soviet Union*.

Mrs. Charles E. Moore, President, announced March 1 was selected by the Auxiliary committee for an informal dinner dance to be held at the San Jose Country Club for members and their husbands.

Mrs. John Hunt Shephard, Chairman of the State Convention, to be held at Del Monte in May, urged all members to take an active part in the various committees.

MRS. DANIEL BILKER,
Publicity Chairman.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 7-11. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Del Monte, May 3-6. F. C. Warnshuis, M. D., 450 Sutter Street, San Francisco, Secretary.

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American College of Physicians, St. Louis, April 19-23. Mr. E. R. Loveland, 4200 Pine Street, Philadelphia, Executive Secretary.

Arizona State Medical Association, Yuma, April 1-3. D. F. Harbridge, M. D., 15 East Monroe Street, Phoenix, Secretary.

Association of Western Hospitals, the Association of California Hospitals, and the Western Conferences of Catholic Hospital Association, Los Angeles, Biltmore Hotel, April 12-15. Secretary, Hotel Whitcomb, San Francisco.

Western Branch of American Public Health Association, Phoenix, Arizona, April 13-15. William P. Shepard, 600 Stockton Street, San Francisco, Secretary.

Medical Broadcasts*

American Medical Association

The American Medical Association and the National Broadcasting Company are presenting the second series of dramatized health broadcasts, under the title, "Your Health." The first broadcast in the new series, the thirty-second dramatized cooperative broadcast under the title "Your Health," was given October 13, 1936. The theme for 1936-1937 differs slightly from the topic in the first series, which was "Medical Emergencies and How They Are Met." The new series is built around the central idea that "one hundred thousand American physicians in great cities and tiny villages, who are members of the American Medical Association and of county and state medical societies, stand ready, day and night, to serve the American people in sickness and in health."

The program will be on the Blue network.

The time of the broadcast is Tuesday afternoon, one o'clock, Pacific time.

The topics are announced monthly in advance in *Hygeia*, the health magazine, and three weeks in advance in each issue of the *Journal of the American Medical Association*.

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San Francisco County Medical Society

A radio broadcast program for the San Francisco County Medical Society for the month of April is as follows:

Tuesday, April 6—KYA, 6 p. m.

Tuesday, April 13—KYA, 6 p. m.

Tuesday, April 20—KYA, 6 p. m.

Tuesday, April 27—KYA, 6 p. m.

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Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of April is as follows:

Thursday, April 1—KECA, 10:45 a. m. The Road to Health.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Saturday, April 3—KFI, 9:15 a. m., The Road to Health.
Saturday, April 3—KFAC, 10:15 a. m., Your Doctor and You.

Thursday, April 8—KECA, 10:45 a. m., The Road to Health.

Saturday, April 10—KFI, 9:15 a. m., The Road to Health.

Saturday, April 10—KFAC, 10:15 a. m., Your Doctor and You.

Thursday, April 15—KECA, 10:45 a. m., The Road to Health.

Saturday, April 17—KFI, 9:15 a. m., The Road to Health.

Saturday, April 17—KFAC, 10:15 a. m., Your Doctor and You.

Thursday, April 22—KECA, 10:45 a. m., The Road to Health.

Saturday, April 24—KFI, 9:15 a. m., The Road to Health.

Saturday, April 24—KFAC, 10:15 a. m., Your Doctor and You.

Thursday, April 29—KECA, 10:45 a. m., The Road to Health.

Corrections.—The stenographic report of the Coronado Clinical-Pathological Conference appeared in the March issue (pages 151-157). Much to our regret a number of errors appeared therein: F. Volhard and Th. Farr were written Bolard and Farre; Clifford Allbut was Clifford Orbutt; v. Basch was Bausch; Gull and Sutton appeared Gullen Sutton; Emanuel Libman for Manuel Lipman; Pel-Ebstein for Pel Epstein; Buerke for Bunting.

University of California Medical History Will Be Reviewed.—The history of medicine in California from the time that the Indians experimented with the old reliable Jimson weed, up to the period of deep radiation, ethylene gas and cesarean section, is to be reviewed in a series of seminars at the University of California Medical School, to which all members of the profession are invited. The seminars are to be held under the direction of the Division of Medical History, of which Dr. Langley Porter, Dean of the Medical School, is the head.

The first of the seminars was held on Wednesday, March 24, when Dr. H. Harris, associate professor of clinical medicine, told how the site for the Medical School was obtained and how the first buildings were constructed. On Wednesday, March 31, Dr. E. L. Gilcreest, instructor in surgery, spoke of Dr. H. H. Toland and his work. The school, established by Doctor Toland at the end of the Civil War, became the nucleus of the present imposing Medical Center, and much of the early history of the school revolves around this famous old-time practitioner. On Wednesday, April 14, Dr. W. I. Terry, clinical professor of surgery, will discuss Dr. T. W. Huntington. On April 21, Dr. Chauncey W. Leake, professor of pharmacology, will speak of Dr. James Black, and in the concluding seminar on April 28, Dr. H. C. Moffitt, clinical professor of medicine, will talk on the life and career of Dr. William Watt Kerr. Doctor Huntington, Doctor Black, and Doctor Kerr were outstanding figures in the history of California medicine, doing their work at a time when the establishment of medicine and medical practices on the last frontier vied in interest with the stamping out of banditry and the establishment of some semblance of law and order.

Each of the lectures will be held at 8 p. m. in Toland Hall, in the University Hospital. This hall was named in honor of Doctor Toland, who is the subject of Doctor Gilcreest's talk.

First Federal Old-Age Benefits Payments Certified by Social Security Board.—The Social Security Board today started another chapter in this nation's social legislation history by placing its approval on the first eight claims filed for lump-sum payments since the inauguration of the Social Security Act's federal old-age benefits program on January 1, 1937. More than 24,500,000 wage earners are now accumulating credits toward the monthly annuities for life, payment of which will begin to qualified persons in 1942. . . .

A lump-sum payment is made to a worker who reaches 65, in the event he is not eligible for monthly retirement benefits, or to his estate if he dies before 65. The settlement is made on the basis of 3½ per cent of the wages received after December 31, 1936. A worker is not required to retire at 65 to receive the lump-sum benefit.

The Board explained that every worker, no matter how young he is when he enters employment covered by the act, will receive in benefits more than he has paid in taxes on his wages under the act. The eight claims certified today are for 3½ per cent of wages received. Those who will receive these sums paid a tax of only 1 per cent of their wages.

The Board's actuaries have calculated that claims may be made by 123,000 persons who reach 65 during 1937. The estimated number of claims filed by workers who became 65 prior to 1942 may increase in 1938 to approximately 136,000 and probably will continue to grow slowly until 1942, when a downward trend is foreseen.

The Board expects payment of death claims will increase slowly for a number of years. Actuarial figures place the number of death claims that may be made during the present year at approximately 191,000. In 1938, it is expected that this number may increase to approximately 194,000 and will continue to grow until 1980, when the figure for 1937 will be about doubled.

The payment of lump-sum benefits, the first of which were authorized today, is preliminary to the Social Security Act's major program of monthly old-age retirement benefits, for which payment begins in 1942. Benefits, ranging from \$10 to \$85 a month for life, will be paid to qualified individuals on retirement from regular employment at 65 or over who have received a total of \$2,000 or more in wages earned in five or more different calendar years after 1936 and before reaching age 65.

The number of claims filed for lump-sum payments is increasing, the Board reported, and procedures for prompt settlement are now being developed. Claims may be filed at any of the 100 field offices of the Board for forwarding to Washington or may be mailed directly to the Board in Washington.

The Board stated that its personnel in these field offices throughout the country is now equipped to give assistance to claimants in the preparation of their claims or in securing the information necessary to expedite payment of their claims. It was indicated that the personnel of the Board will be adequate to handle all such cases, so that no claimant will require for this purpose the services of anyone not employed by the Board.

Lane Lectures: 1937 Series.—The twenty-sixth course of Lane Medical Lectures will be delivered by Eugene F. Du Bois, A. B., M. D., Medical Director of Russell Sage Institute of Pathology, Professor of Medicine of Cornell University Medical College, and Physician-in-Chief of New York Hospital, on the evenings of April 5, 6, 7, 8, and 9, at 8:15 o'clock in Lane Hall, Stanford University School of Medicine, Sacramento Street near Webster, San Francisco.

The medical profession, students, teachers, and research workers in medicine and allied sciences are cordially invited to attend.

The Lane Medical Lectures were founded in 1896 by the late Dr. Levi Cooper Lane and have been given as follows:

1896. Sir William Macewen, M. D., Regius Professor of Surgery, University of Glasgow—Surgery of the Brain.
1897. Christopher Heath, F. R. C. S., England, Professor of Clinical Surgery, University College, London—Congenital Malformations, Aneurism, and Other Surgical Topics.

1898. Sir Thomas Clifford Allbutt, M. D., F. R. S., Regius Professor of Physics, University of Cambridge, England—Diseases of the Heart.
1899. Nicholas Senn, M. D., Ph. D., LL. D., Professor of Surgery, Rush Medical College—Topics in General Surgery.
1900. Sir Michael Foster, K. C. B., D. C. L., Professor of Physiology, University of Cambridge, England—History of Physiology.
1901. Sir Malcolm Morris, F. R. C. S., Edinburgh, M. R. C. S., England, Surgeon, Skin Department, St. Mary's Hospital, London—Social Aspects of Dermatology.
1902. Sir Charles B. Ball, M. Ch., F. R. C. S., Ireland, Regius Professor of Surgery, University of Dublin—Diseases of the Rectum.
1903. Oscar H. Allis, M. D., Philadelphia, Pennsylvania. Dislocations and Fractures Involving Larger Joints.
1904. William H. Welch, M. D., LL. D., Professor of Pathology, Johns Hopkins University, Baltimore—Infection and Immunity.
1905. Sir Patrick Manson, K. C. M. G., F. R. S., School of Tropical Medicine, London—Tropical Diseases.
1906. John C. McVail, M. D., D. P. H., Cambridge, Glasgow—Practical Hygiene, Epidemics, and Preventive Medicine.
1910. Reginald Heber Fitz, M. D., LL. D., Hersey Professor of Theory and Practice of Medicine, Harvard University, Boston, Massachusetts—A Consideration of Some Features of the Lymphatic System.
1911. Ernest Fuchs, Professor of Ophthalmology in the University of Vienna—The Importance of Ophthalmology in Its Relation to Systemic Diseases.
1913. Sir Edward A. Schafer, LL. D., Sc. D., M. D., Professor of Physiology in the University of Edinburgh—Internal Secretion.
1915. Frank Billings, M. S., M. D., Professor of Medicine in the Rush Medical College, Chicago, Illinois—Focal Infection.
1917. Simon Flexner, M. D., LL. D., Director of Laboratories, Rockefeller Institute for Medical Research, New York City—Physical Basis and Present Status of Specific Serum and Drug Therapy.
1919. Alonzo Englebert Taylor, Professor of Physiological Chemistry, University of Pennsylvania, Philadelphia—The Feeding of the Nations at War.
1921. L. Emmett Holt, M. D., Sc. D., LL. D., Emeritus Professor of Pediatrics, College of Physicians and Surgeons, Columbia University, New York City—Growth and Nutrition.
1924. Ludwig Aschoff, M. D., Professor of Pathology, University of Freiburg, Germany—Selected Topics in Pathology.
1925. Vittorio Putti, M. D., Professor of Orthopedic Surgery, University of Bologna, Director Rizzoli Institute of Bologna, Italy—Selected Topics in Orthopedic Surgery.
1928. F. d'Herelle, M. D., Professor of Bacteriology, Yale University, New Haven, Connecticut—Bacteriophagy.
1929. Walther Straub, M. D., Ph. D., Professor of Pharmacology, University of Munich, Munich, Germany—Selected Topics in Pharmacology.
1930. Charles R. Stockard, M. D., Ph. D., Sc. D., Professor of Anatomy, Cornell University Medical School, New York City—Constitution.
1933. J. C. Drummond, Sc. D., Professor of Biochemistry, University College, University of London, London, England—Biochemical Studies of Nutritional Problems.
1935. G. V. Anrep, M. D., Sc. D., F. R. S., Professor of Physiology, Egyptian University, Cairo, Egypt—Regulation of the Cardiovascular System.

Doctor Du Bois will give the following lectures:

- Lecture 1
April 5—Heat Production and Heat Loss.
- Lecture 2
April 6—Radiation, Convection and Vaporization.
- Lecture 3
April 7—The Significance of the Surface Area of the Body.
- Lecture 4
April 8—The Regulation of Body Temperature.
- Lecture 5
April 9—Chills and Fever.

Southern California Medical Association.—The next semi-annual meeting of the Southern California Medical Association will be held in Coronado, at the Hotel Del Coronado, on April 9 and 10.

Guest speakers will include Dr. Eugene F. DuBois, Professor of Medicine, Cornell Medical College and Medical Director of the Russell Sage Institute, New York City, and Dr. Hugh Cabot of the Mayo Clinic, Rochester.

This will be an unusually good meeting and a large attendance is expected. Make your reservations at the hotel now.

For further information, write to Robert W. Langley, M. D., Acting Secretary, Los Angeles.

Dengue in 1934-1935.—In 1934 two cases of this disease were reported in San Francisco. These are the first cases reported to have originated in Northern California. While clinically they were typical of dengue, there is the disturbing factor that, so far as is known, no mosquitoes known to transmit the disease have been found in the vicinity of San Francisco. The cases were reported in detail in the *Archives of Internal Medicine*, 56:1067-1096, December 1935, by Dr. G. Cheney.

Cases previously reported are:

In 1922, three cases were reported in Southern California, and imported from the epidemic area in Texas.

In 1929, three cases; 1932, one case; 1933, one case. All these were reported in Southern California, and the diagnosis may be open to some question.

International Congress on Hepatic Insufficiency.

While the Universal Exhibition is being held in Paris, the International Congress on Hepatic Insufficiency will be in session at Vichy on the 16th, 17th and 18th of September, 1937, under the presidency of a member of the Academy of Medicine, Prof. Maurice Loeper, of Paris. It will be divided into two sections: (1) Medicine and biology; (2) Medical, surgical, and hydrological therapy.

Papers will be submitted in the two sections by gentlemen of different countries.

It may be recalled that this congress will be preceded by the Second International Congress on Gastro-Enterology, to take place in Paris on September 13, 14, and 15, 1937, under the presidency of Prof. Pierre Duval, at which two questions will be discussed:

1. The early diagnosis of cancer of the stomach, under the presidency of Professors P. Duval and Gosset of Paris, and of Professor Konjetzny of Berlin.

2. Acute and chronic occlusion of the small intestine: Authors have been selected in England, Belgium, Spain, the United States, Italy, and Poland for papers dealing with this latter question.

Those desiring to attend these congresses may receive information by applying to Dr. Anthony Bassler, 121 East Seventy-first Street, New York City. A large contingent from this country are arranging to go.

Automobile Mortality Summary.—Report by the Department of Commerce Bureau of the Census, Washington, D. C., of deaths from automobile accidents in eighty-five major cities for four-week period ending February 13, 1937, includes, among other cities, the following:

	Total Deaths for—			
	Four Weeks Ending		Eight Weeks Ending	
	Feb. 13, 1937	Jan. 16, 1937	Feb. 13, 1937	Jan. 15, 1936
Total (85 cities)	715	975	486	1,690
Chicago	50	79	44	129
Long Beach	7	7	3	14
Los Angeles	50	77	53	127
New York	78	98	42	176
Oakland	11	6	6	17
Philadelphia	25	35	16	60
St. Louis	11	12	18	23
Salt Lake City	6	5	5	11
San Diego	8	6	2	14
San Francisco	8	7	3	15
Seattle	6	15	8	21
Spokane	0	10	2	10

Poliomyelitis in California, 1934-1935.—In 1934 California experienced its largest epidemic of poliomyelitis, having 3,399 cases, with 110 deaths reported.

During the past ten years we have had three extensive epidemics:

Year	Cases	Deaths
1926	187	30
1927	1,298	224
1928	303	80
1929	171	46
1930	1,903	157
1931	293	48
1932	191	31
1933	170	14
1934	3,399	110
1935	831	67

The age distribution of the cases reported in 1935 was very interesting:

	Cases	Per Cent
Under 1 year	30	0.80
1 to 4 years	505	14.86
5 to 9 years	888	26.13
10 to 14 years	677	19.92
15 to 19 years	334	9.83
20 to 24 years	309	9.09
25 to 34 years	402	11.83
35 to 44 years	145	4.26
45 to 54 years	42	1.24
55 plus	21	.62
Adult	6	0.17
Unknown	40	1.17
	3,399	100.00

Cases by Months—1934

January	25
February	27
March	18
April	38
May	314
June	1,192
July	767
August	429
September	226
October	186
November	104
December	73
Total	3,399

This epidemic has some interesting features. The fatality rate was unusually low—3.2 per cent compared with 8.3 per cent in 1930, and 17.3 per cent in 1927 over previous epidemic years. There is some indication that the disease is less virulent; however, a large part of this reduction in fatality is due to the inclusion of mild abortive cases which previously were not diagnosed and reported as cases. The percentage of paralytics in this epidemic is for the same reason correspondingly low.

Another interesting feature was in institutional outbreaks experienced in Los Angeles and Orange counties. This is unique in the history of poliomyelitis. In the Los Angeles Isolation Hospital during the epidemic of 1934 over 136 nurses, attendants, and doctors contracted the infection. In 1935 over forty-five came down with the same disease. In Orange County during the epidemic of 1934 over sixty cases developed poliomyelitis. No definite explanation of these institutional outbreaks has been given, although it has been suggested that excessive fatigue may have been a factor. There was no indication that isolation technique as is usually practiced was not adhered to by the personnel.

Deaths Due to Accidents in City for—

	Eight Weeks Ending			
	Four Weeks Ending		Eight Weeks Ending	
	Feb. 13, 1937	Jan. 16, 1937	Feb. 13, 1937	Jan. 15, 1936
Total	584	803	369	1,387
Chicago	49	77	44	126
Long Beach	7	7	3	14
Los Angeles	47	58	42	105
New York	78	98	42	176
Oakland	10	6	5	16
Philadelphia	25	34	16	59
St. Louis	11	10	17	21
Salt Lake City	5	4	3	9
San Diego	8	5	1	13
San Francisco	8	7	3	15
Seattle	6	13	4	19
Spokane	0	7	0	7

American Neisserian Medical Society Meeting.—The third annual meeting of the American Neisserian Medical Society will be held on June 8, 1937, in the Senator, Atlantic City.

The program will consist of papers and discussions on the various phases of the management and control of gonorrhea. All who are interested are cordially invited to be present.

The meeting will begin promptly at 10:00 a. m., and will continue through the day. Additional information may be secured from Oscar F. Cox, Jr., M. D., secretary, 113 Bay State Road, Boston, Mass.

Social Security Taxes Now Being Paid.—The federal tax returns required by Title VIII of the Social Security Act are now being filed at a satisfactory rate in the offices of the sixty-four collectors of internal revenue, Commissioner of Internal Revenue Guy T. Helvering recently announced. The commissioner calls attention to the fact, however, that some misunderstanding evidently exists on the part of many taxpayers as to the place to which the returns should be sent and the payments made.

Each employer should file his return on Form SS-1 with the Collector of Internal Revenue for the district in which is located his principal place of business. If the employer has no principal place of business in the United States he should file his return with the Collector of Internal Revenue, Baltimore, Maryland. The tax must be paid at the time the return is filed. Checks, drafts or money orders in payment of these taxes should be made payable to the Collector of Internal Revenue.

Title VIII of the Social Security Act, approved August 14, 1935, imposes an excise tax upon employers and an income tax upon their employees measured by the amount of wages paid on and after January 1, 1937, with respect to employment on and after that date. The rate of each tax for the years 1937, 1938 and 1939 is 1 per cent of the wages paid. The law provides that the employer shall collect the employee's tax by deducting the amount of such tax from the wages as and when paid. The returns now being filed on Internal Revenue Form SS-1 cover the month of January, 1937. Every employer who, during any calendar month beginning after December 31, 1936, employs one or more individuals in a business not specifically exempt from the tax is required to make a return on Form SS-1. The returns for the month of January, 1937, must be filed not later than the end of February.

The taxes imposed by Title VIII of the Social Security Act have created a new class of federal taxpayers, many thousands of whom have heretofore had no occasion to send tax returns and payments to the various internal revenue collectors. This, no doubt, accounts for the fact that some misunderstanding exists on the part of a portion of these taxpayers in regard to meeting their obligations to the Government under the Social Security Act. Some of the returns and moneys are being sent to the Social Security Board at Washington and some of the taxpayers are making their returns to the various field offices of the Social Security Board, while still others have sent their returns and remittances to the Bureau of Internal Revenue at Washington. The Bureau of Internal Revenue states that every possible effort is being made to refer the returns and moneys promptly to the appropriate collectors of internal revenue, where the moneys will be deposited in the designated depository banks and the returns listed for assessment. It is expected that before the end of the month more than two million returns will have been received in the sixty-four collectors' offices.

Prior to the effective date of the taxes, the sixty-four collectors of internal revenue located throughout the United States compiled lists of the persons and firms apparently subject to the tax and distributed blank returns to them. All possible efforts were made to place a blank in the possession of every potential taxpayer. However, it was explained by the Bureau of Internal Revenue that failure to receive a blank return form did not excuse a taxpayer for failure to file his return and pay the tax on time. Any person liable for the tax who failed to receive a form may secure a blank by making a request upon the Collector of Internal Revenue for his district. The law provides penalties both for delinquency in filing the return and for failure to pay within the required time.

Pacific Coast Society of Obstetrics and Gynecology. The next meeting of the Pacific Coast Society of Obstetrics and Gynecology will be held at San Francisco, November 3 to 6, at the Fairmont Hotel.

Menninger Clinic.—Guest speakers at the third annual postgraduate course on Neuropsychiatry in General Practice, April 19 to 24, inclusive, at the Menninger Clinic, Topeka, Kansas, will be:

Dr. Franklin G. Ebaugh, Denver, Colo., professor of psychiatry, University of Colorado Medical School; director of Colorado Psychopathic Hospital; director, division of psychiatric education, National Committee for Mental Hygiene.

Dr. Winchell McK. Craig, Rochester, Minn., of the Section on Neurology, surgical, the Mayo Clinic; associate professor of neurosurgery, University of Minnesota, graduate School of Medicine.

Dr. J. W. Kernohan, Rochester, Minn., pathologist to the Mayo Clinic; associate professor of pathology, University of Minnesota.

Automobile Accident Experience.—Many odd and surprising facts about America's automobile accident experience in 1936 are revealed in a new booklet entitled, "You Bet Your Life," just issued by the Travelers Insurance Company of Hartford, Connecticut. By comparing the hazards of traffic with some of the common forms of gambling, the editors have put forth a clever argument against reckless driving and walking.

The traffic gambler, the booklet points out, is eleven times as likely to be killed or injured in an automobile accident as the holder of a sweepstakes ticket is to win even a small prize. He is thirty-two times as likely to be killed on the highways as the holder of a sweepstakes ticket is to collect a major prize.

The pedestrian who risks all the remaining minutes of his life to save a single minute by crossing the street in the middle of the block, the record shows, is as foolish as the man who would bet seventeen million dollars against one dollar that he could toss a booklet into the air and catch it as it falls. He probably would win, but the small gain would not be worth the tremendous risk. . . .

After analyzing reports of 36,800 fatalities and 967,840 injuries in traffic accidents last year, the company's statisticians point to these interesting and little-known facts about accidents:

Nearly 94 per cent of drivers involved in fatal accidents are male and only 6 per cent female. It does not necessarily follow that women are safer drivers than men, they carefully point out, because adequate data on the relative exposure are lacking.

More than 97 per cent of drivers involved in fatal accidents have had one or more years' driving experience.

More than 75 per cent of all fatal accidents occur when the road is dry. More than 85 per cent of all fatal accidents occur in clear weather.

Saturday was the most dangerous day for driving in 1936, and Tuesday was the safest. In 1935, the fewest number of accidents occurred on Wednesday. More persons were killed last year between seven and eight o'clock in the evening than at any other hour, but the heaviest injury toll came between five and six o'clock in the afternoon.

About 60 per cent of the fatalities occurred during the hours of darkness, when there was only about 25 per cent of the total traffic on the road.

Nearly 80 per cent of the total vehicles involved in fatal accidents were passenger cars.

More than 93 per cent of all vehicles involved in fatal accidents were in apparently good condition when the accident occurred.

The number of Americans killed in traffic accidents during the last fifteen years exceeds by a wide margin the number of Americans killed in action or died of wounds during all the wars in which the nation has ever engaged.

Single copies or quantities of the booklet for club and school use may be obtained gratis by writing the company or any of its agents.

Qualifying Certificate (Basic Science) References.*

A list of reports on qualifying certificate laws, printed in *CALIFORNIA AND WESTERN MEDICINE*, is as follows:

Vol. 32, No. 4, April, 1930, page 288. One hundred and eighty-sixth meeting of the Council of the California Medical Association. Item 30, Medical Practice Act and Basic Science Act.

Vol. 32, No. 6, June, 1930, page 430. Report of Special Committee on Revision of Medical Practice Act and of a Possible Basic Science Act.

Vol. 34, No. 6, June, 1931, page 448. Report of Special Committee on California Medical Practice Act and on a Proposed Qualifying Certificate (So-Called Basic Science) Law.

Vol. 35, No. 3, September, 1931, page 228. Editorial.

Vol. 35, No. 3, September, 1931, page 239. Miscellany.

Vol. 36, No. 2, February, 1932, page 128. Report of Special Committee on Medical Practice Act and on Qualifying Certificate (So-Called Basic Science) Law.

Vol. 36, No. 6, June, 1932, page 439. Report of Special Committee on California Medical Practice Act and on a Qualifying Certificate (So-Called Basic Science) Law.

Vol. 41, No. 5, November, 1934, page 339.

Vol. 42, No. 1, January, 1935, pages 39 and 53.

Vol. 43, No. 4, October, 1935, page 304.

Vol. 43, No. 5, November, 1935, page 321. Editorial.

Vol. 43, No. 6, December, 1935, page 395. Editorial.

Vol. 44, No. 1, January, 1936, page 2. Editorial.

Vol. 44, No. 4, April, 1936, page 252. Editorial.

Vol. 44, No. 4, April, 1936, page 349. Special Article.

Vol. 45, No. 3, September, 1936, page 218. Editorial.

Vol. 46, No. 1, January, 1937, page 4. Editorial.

Financial Statement of State Compensation Insurance Fund.—Commissioner Frank C. MacDonald reported the following financial statement of the State Compensation Insurance Fund, which is conducted under the supervision of the Industrial Accident Commission of California:

During 1936, the premiums written by the State Compensation Insurance Fund amounted to \$8,244,000. This is the largest volume ever written by the Fund, and exceeds the next highest year, which was 1930, by \$500,000. The increase in premiums for 1936 over 1935 was \$1,700,000 or 26 per cent. This is the largest amount that any year has ever increased over any previous year. It is an increase of nearly 100 per cent in volume of business over 1933.

The reserves for compensation payments and expense, which are held for the protection of injured workmen and their dependents, have been increased to over \$8,200,000, an increase over December 31, 1935, of over \$1,200,000. There has been a corresponding increase in investment of funds to take care of these reserves. The total assets of the Fund have increased to \$13,491,000, the largest in its history.

Over \$1,000,000 is maintained in cash and short-term U. S. Treasury notes, and \$11,620,000 are invested in bonds, which are legal for savings banks in California. Of this amount, \$2,265,000 is invested in bonds of the State of California and \$5,921,000 in bonds of municipalities and other public agencies of California. Thus, over \$8,000,000 is invested in the obligations of California governmental units, all of the highest rating.

The underwriting exhibit is one of the best in the Fund's history. The financial statement for 1936 shows a loss ratio of 60.50 per cent, and an expense ratio of 14.17 per cent. This expense ratio is the lowest of any compensation insurance company in California, as most California companies have an expense ratio of approximately 40.6 per cent.

The dividends declared by the Fund on policies issued during 1935 have been increased substantially over those on 1934 and immediately preceding years of issue. It is anticipated that on 1935 year of issue policies the dividends will exceed \$2,000,000, the largest amount ever paid on any one year of issue. The excellent underwriting results during the 1936 calendar year indicate that the Fund will be able to maintain the same substantial return to policyholders on policies issued during 1936.

* See also Report of Special Committee on Qualifying Certificate Act in Supplement of this issue (Pre-Convention Bulletin section), page 54.

Lectures on Medical History of California.—The Division of Medical History of the University of California Medical School has arranged a series of talks on the medical history of California, with particular reference to the physicians who were instrumental in founding the University of California Medical School and those who devoted their efforts to building up the various activities of the School. The schedule is as follows, all of the talks being in Toland Hall, University Hospital, at 8 p.m.

Thursday, March 25—Dr. Henry Harris, "How the site of the University of California Medical School was chosen."

Wednesday, March 31—Dr. E. L. Gilcreest, "Toland."

Wednesday, April 7—Dr. R. T. Legge, "McLean."

Wednesday, April 14—Dr. W. I. Terry, "Huntington."

Wednesday, April 21—Dr. C. D. Leake, "Blake."

Wednesday, April 28—Dr. H. C. Moffitt, "William Watt Kerr."

The medical profession and all others interested are cordially invited to attend these talks.

Botulism in California.—During 1934 there were six cases, with six deaths, while in 1935 there were twenty cases, with only seven deaths. During the first six months of 1936 only one case occurred. Home-prepared products were involved, the products being home-canned mushrooms, home-prepared soy bean paste, home-canned string beans, home-canned corn and home-made cheese; in one instance either home-canned corn or salmon. In one outbreak an imported commercial canned antipasto was incriminated; however, it could not be confirmed bacteriologically.

A few of the outbreaks deserve particular attention. Three members of a family ate home-made cheese, all developing typical symptoms, one ending fatally. The preparation of the cheese was very significant. It was made in a large ten-gallon earthen crock. The top of the crock was covered with a cloth, a hole dug in the ground and the crock buried bottom up, where it remained six to eight months before being dug up and portions of it eaten. The portion in contact with the soil was found to contain large quantities of *Cl. botulinus*, while the bottom of the jar was free from contamination—the cheese having a uniform yellow color.

The largest outbreak involved ten cases, with three deaths. Epidemiologically, a salad containing an imported antipasto seemed to be the most likely food product; however, the laboratory recovered *Cl. botulinus* out of a partially used jar of home-canned mushrooms found on the premises. This jar was not supposed to have been used by any of the victims of the outbreak.

Children's Books Help Out Doctors at University of California Hospital.—There is nothing in any record to show that Little Red Riding Hood, Old King Cole or other Mother Goose characters went around carrying surgeon's scalpels or rolls of bandages. But there is considerable evidence to show that these worthy characters are taken into consultation by the doctors in the children's wards in the University of California Hospital while the little patients are on the road to recovery, and, to say the least, they have been a big help in taking the minds of the children off both their physical and their mental ailments.

A study of the situation made by Clifton E. Brooks, a graduate of the University, reveals that there is nothing more effective in subduing restlessness and peevishness in long periods of convalescence than well-written and entertaining children's books. As there are many children passing through the hospital whose parents are unable to supply this need, Brooks makes the plea that the public at large, and particularly the alumni of the University, send in as many Mother Goose and other books as possible.

"One of the most important departments of the hospital and the School of Medicine is that of pediatrics, the treatment of children's diseases," Brooks says, in a message to the alumni. "In this department are many chronic cases of diabetes and heart ailments. There are also many cases of convalescence from various acute conditions, all of which require quiet rest in bed. All parents know how extremely difficult it is to keep quiet an ailing or convalescent child without some well-selected aid in the shape of an entertaining book to keep his mind occupied."

Typhoid Fever in 1934-1935.—In 1934 there were 626 cases of typhoid fever in California with 80 deaths, and in 1935, 534 cases with 75 deaths. Practically all of these were sporadic cases, no major epidemic being reported. In the spring of 1936 a very interesting outbreak, involving twenty-nine cases, occurred in a small community in the Sacramento delta region. Investigation proved this outbreak to have been water-borne. The water supply was from a deep, drilled well, the casing of which had rusted through about three feet below ground level, permitting water to seep in. This seepage water was heavily polluted. It was found that a twelve-inch sewer line passed within a few feet of the well, and every joint leaked. Heavy rainfall raised the ground water level and allowed sewage-polluted water to pass through the well casing into the well. When a new supply of water was furnished, the outbreak subsided.

Diseases Greatly Affect History of Peoples, Nations.—Nations and races, since the remotest times, have been profoundly affected by epidemics and long-prevailing diseases, according to Dr. Alfred C. Reed, professor of tropical medicine at the University of California.

Doctor Reed's theory that epidemic and endemic diseases have helped greatly to shape the history of certain regions and peoples is expressed in the March issue of the *Scientific Monthly*.

The history of the plague, says Doctor Reed, is particularly interesting. For example, in the fifth century B. C. it swept through Athens, so weakening the Attic manpower that Athens was later beaten in battle at Syracuse and the road paved for the fall of the Golden Age of Greece. Such diseases as typhus, cholera, yellow fever, smallpox, and measles have been particularly deadly. Influenza, in 1918-1919, added its name to the list of great epidemic diseases.

Unlike the plagues, which rage for a certain period of time and then vanish without leaving lasting social scars, the so-called endemic diseases cause the steady deterioration of the populations on which they prey. Malaria, alone, says Doctor Reed, has supplied countless examples of the racial weakening and inefficiency which such diseases bring. Other examples, according to the author, are leprosy, which was a great problem in fourteenth century Europe, and is now increasing in central Africa; sleeping sickness, which has stunted the cultural growth of the African negroes; and syphilis, which has recently become the object of a world-wide medical offensive.

Association of Western Hospitals.—The Association of Western Hospitals announces the preview of the 1937 convention program:

The eleventh annual convention and display of exhibits of the Association of Western Hospitals, the Association of California Hospitals, the western conferences of the Catholic Hospital Association, and allied groups and sections, will be held April 12-15, Biltmore Hotel, Los Angeles.

The theme of the convention this year is: Hospital Service Is a Profession—How Well Do We Carry Out Its Traditions?

To effect this theme, the Program Committee has planned a concentrated study of some of the major hospital problems. This study will be conducted under the leadership of competent, colorful authorities, with opportunity for pertinent questioning and discussion. The responsibilities of hospitals to the public, to the patient, to the employees, will be stressed throughout the convention.

The Program Committee is planning fewer and better speeches, more and better discussions. General assemblies, scheduled without conflict from other sessions, will be held twice daily. In each of these sessions, you will hear an able speaker, one chosen for knowledge of the subject, ability to deliver his message, and for courage to tell the truth, even though it startles.

Periods for discussions will be provided after each major session. They will be led by competent chairmen, assisted by discussants chosen for special knowledge of the subject.

A convention program, filled but not crowded! The committee is confident you will like it. Do not miss it!

Human Voice Put Under Microscope at Medical School.—An actual demonstration of how the human voice may be studied under the microscope as an aid in both the detection and the treatment of certain diseases was recently given by Dr. Paul Moses, lecturer in voice and speech defects in the University of California Medical School, in a series of lectures at the School.

Vacancies on Medical Staffs in State Institutions.—Opportunities for physicians to enter the California State service were given a boost on March 9, 1937, when the State Personnel Board announced examinations for four positions at salaries of \$200 per month plus living costs for each doctor and his family, and another position at \$100 per month plus living costs. The positions were all in institutions operated by the State.

Applications to take the examinations must be filed with the State Personnel Board in Sacramento. Residence requirements for these positions have been set aside by the State Personnel Board, and applications will be received from physicians who are not residents of the State of California.

University of California Medical School Had Medical Program for Charter Week.—The University of California Medical School has prepared a notable program as its part in the Charter Week observance of the University, and has invited all members of the medical profession to participate, whether they are graduates of the University or not. The program was carried out on Wednesday, March 24, and consisted of operative clinics, lectures on late developments in both medicine and surgery and the annual dinner of the University of California Medical School Alumni Association, which was held at the Bohemian Club. This dinner was addressed by Dr. Monroe E. Deutsch, vice-president and provost of the University and Dr. Herbert C. Moffitt, clinical professor of medicine.

Vaccination of Cattle Against Bang's Disease: Still Experimental.—The vaccination of cattle against Bang's disease during calfhood is a promising means of combating this serious cattle malady, says Dr. J. R. Mohler, chief of the Bureau of Animal Industry, United States Department of Agriculture. "Yet," he cautions, "this procedure is still in the experimental stage and livestock owners hesitate to place faith in claims that promise more than scientific findings to date warrant."

To correct erroneous and misleading statements that have come to its attention regarding vaccination for Bang's disease, the Bureau summarizes present scientific knowledge on this subject:

The Bureau's investigators have found a vaccine prepared with a *Brucella abortus* strain of low virulence, and used only on calves between 4 and 8 months old, to be an encouraging means of coping with Bang's disease. Calves have appeared to be more resistant than mature unbred animals to the vaccinal infection, and the agglutination reactions induced by the vaccine injections have given indication of being of shorter duration in calves than in unbred heifers of near breeding age or in unbred cows. . . .

The Bureau of Animal Industry is coöperating with about 250 herd owners in different states in a calfhood-vaccination experiment on farms where 15 per cent or more cattle have reacted to the Bang's disease test. It is proposed to continue this experiment until such time as all cattle in these herds will be those that were vaccinated when calves.

Unification of Medical Curriculum Deemed Desirable. Medical education has become too specialized and standardized, and medical educators are too prone to teach individual divisions of medical science and practice without regard for their relationship to the whole.

This statement of the late Williams McKim Marriott, M.D., dean of the University of California Medical School, has been reprinted from the *Southern Medical Journal*.

Medical schools, said the late dean, depend too much on the ability of the student to organize the material which

is given him in class. The component parts of a good medical education are given him, but little attempt is made by the faculty to make him realize their relation to the whole.

It would be better, said Doctor Marriott, if, from the very start of the course, the student could have before him some picture of the complete medical education. The curriculum of the medical school should be so coordinated that each separate subject would be taught not as an isolated branch, but as part of a central idea.

There should be no break between preclinical and clinical instruction, according to the article. The study of medical sciences should be continued while clinical study is being carried on.

The unification of the curriculum, said Doctor Marriott, would necessarily mean the breaking down of some department lines and a mingling of the members of the departments. Frequent symposiums and comprehensive examination in which many branches of medical science are treated would be represented would be beneficial.

LETTERS

Concerning ownership of x-ray plates.

San Francisco, March 10, 1937.

To the Editor:—Inasmuch as there is now pending before the California Legislature numerous bills for the regulation of the practice of medicine, I believe it timely to call to the attention of my colleagues the following case. Within the last ten or more years the atmosphere has become so charged with court actions against the physician and surgeon that every act of the profession is an excuse for legal procedure.

The action brought against me was by husband and wife, both of whom had been patients for which both medical and surgical services had been rendered. They demanded recovery of x-ray films, laboratory reports, and damages of \$1,250. These reports they asked be turned over to them for possession, refusing the offer made by me that I would allow any physician to whom they wished to go subsequently, the opportunity to see and obtain all information in my hands.

The case was heard in the municipal court of Judge Alfred J. Fritz, San Francisco. In deciding this case in favor of the physician, Judge Fritz's decision was as follows: "There are no decisions in the State of California on the point, and the only case in the United States that counsel for either side have been able to find is that of *McGarry vs. J. A. Mercier Co.*, decided by the Supreme Court of Michigan on September 9, 1935, and appearing in Volume 262, N. W. Reporter, at page 296, which was concurred in by the entire bench."

In that case, Judge Fritz quotes in part from the opinion of the court, as follows:

In the absence of agreement to the contrary, such negatives are the property of the physician or surgeon who made them incident to treating a patient. It is a matter of common knowledge that x-ray negatives are practically meaningless to the ordinary laymen. But their retention by the physician or surgeon constitutes an important part of his clinical record in the particular case, and in the aggregate these negatives may embody and preserve much of value incident to a physician's or surgeon's experience. They are as much a part of the history of the case as any other case record made by a physician or surgeon. In a sense they differ little, if at all, from microscopic slides of tissue made in the course of diagnosis or treating a patient, but it would hardly be claimed that such slides were the property of the patient. Also, in the event of a malpractice suit against a physician or surgeon, the x-ray negatives which he has caused to be taken and preserved incident to treating the patient might often constitute the unimpeachable evidence which would fully justify the treatment of which the patient was complaining. In the absence of an agreement to the contrary, there is every good reason for holding that x-rays are the property of the physician or surgeon rather than of the patient . . . who employed such phy-

sician or surgeon, notwithstanding the cost of taking the x-rays was charged to the patient . . . while not fully to the point, it has been indicated by court decisions that the negatives of an ordinary photograph, in the absence of an agreement otherwise, belongs to the operating photographer, though his use thereof may be restricted.

This case and decision will undoubtedly set a precedent in the State of California. I believe that through closer cooperation between the two great organizations, Law and Medicine, in this State as well as throughout the United States, much could be accomplished to establish a better understanding and in this way there might be a marked decrease in all types of court actions against the physician and surgeon. These have become all too frequent, especially in our own locality. The increase of our protection rates bears witness to this fact.

516 Sutter Street.

ROBERT A. OSTEROFF, M.D.

Concerning recent appointments to State Board of Medical Examiners.

The following letter was sent to Governor Frank Merriam by Dr. William R. Molony, President of the State Board of Medical Examiners:

Los Angeles, California,
March 5, 1937.

Hon. Frank Merriam
Governor of the State of California
Sacramento, California

Dear Governor:

I want to thank you for your very cordial expression of confidence in the Board of Medical Examiners as shown in your recent reappointment of Doctors Charles E. Schoff and William H. Geistweit, Jr. These physicians have served with distinction and have rendered valuable service to the people of California as members of the Board of Medical Examiners.

The medical profession of this State join with me in expressing to you their gratitude and thanks for making it possible to retain these two splendid doctors upon the board.

May I take this opportunity also to tell you of the splendid and worth while service and cooperation shown to the Board of Medical Examiners and the profession of this State by Mr. William G. Bonelli. It is indeed a great pleasure to have associated with us as the Director of Vocational Standards such a fine, understanding and sympathetic person as found in Mr. Bonelli.

I am very cordially yours.

WILLIAM R. MOLONY.

Concerning May Day—Child Health Day, 1937.

The following letters explain themselves:

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU
WASHINGTON

February 20, 1937.

Dr. George Kress, Editor
CALIFORNIA AND WESTERN MEDICINE
304 South Broadway
Los Angeles, California
My dear Doctor Kress:

Dr. W. W. Bauer, Director, Bureau of Health and Public Instruction of the American Medical Association, has suggested that we send to you the enclosed Suggestions for the Observance of May Day—Child Health Day, 1937, with the request that you give same notice of it in your State medical journal.

As you will notice, the State health officer appoints a May Day chairman for each State, who is usually the director of the division of maternal and child health in the State Department of Public Health. If you can give space for an article on child health in your April or May issue, the director of that division will probably be glad to supply you with information on child health in your State to include in the article.

We will appreciate whatever you find it possible to do to emphasize the importance of "Health Protection for Every Child" in connection with May Day—Child Health Day, 1937.

Sincerely yours,

MARTHA M. ELIOT, M. D.
Assistant Chief.

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU
WASHINGTON

May Day—Child Health Day, 1937
Saturday, May 1

Suggestions for Observance

The Children's Bureau sponsors May Day—Child Health Day activities at the request of the State and Provincial Health Authorities of North America and in accordance with the Congressional Resolution of May 18, 1928, authorizing the President to proclaim May Day as Child Health Day.

Slogan: Health protection for every child.

Objective: To promote the extension of year-round child health services in every community, including services for physically handicapped children.

Leadership: State May Day chairmen will be appointed by State health officers to plan the State Child Health Day program and to arrange for the cooperation of organizations concerned with child health.

State departments of education will be asked to cooperate by planning and directing school Child Health Day programs.

Program: For community groups: (1) an evaluation of child health services in the community based on a survey of existing child health conditions and organization to promote child health, (2) the launching of new local child health projects, and (3) exhibits or programs celebrating gains made.

For children: As a climax for the year's health program—festivals, athletic contests, programs, exhibits celebrating children's growth, vigor, and safety from health hazards.

State and local news stories, radio talks, and speeches.

Requests for information on State programs or for further material should be sent to May Day chairmen in State health departments.

KATHARINE F. LENROOT,
Chief.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, Esq.
San Francisco

Malpractice Liability of an Operating Surgeon for the Negligence of a Nurse Assisting at the Operation

Several years ago a physician performed an operation for the purpose of removing the gall-bladder of a patient in a county hospital. Two nurses employed by the hospital assisted the operating surgeon. One was an instructor of nurses at the hospital; the other had about eighteen months' nursing experience, and this operation was the first time she had been in an operating room to attend an operation of any kind.

Neither nurse counted the number of sponges that were brought into the operating room or the number that were used and thrown into the receptacle after use. The operating surgeon later testified that an announcement was made by someone that the sponge count was correct; that he viewed the field of operation, saw no sponges, and closed the incision.

Unfortunately, a sponge remained in the patient's abdomen and she died following a second operation performed to remove the sponge. Within a year a malpractice action was filed against the supervisors of the county and the operating surgeon. Because of the rule of law which grants an immunity to counties for the negligence of officers or employees in county hospitals, the case was dismissed as to the supervisors. (For the law on this point, see CALIFORNIA AND WESTERN MEDICINE, pp. 516-517, December, 1936.)

The case proceeded as against the surgeon alone. Eventually it reached the Supreme Court of this State, where a judgment against the surgeon was upheld on two separate grounds: First, that an operating surgeon is legally responsible for all of the acts or omissions of nurses, no matter by whom employed, assisting in a surgical operation; second, that in a certain type of malpractice case, including sponge cases, the doctrine of *res ipsa*

loquitur applies. The phrase *res ipsa loquitur*, when applicable to a malpractice case, means, generally speaking, that it is only necessary for the plaintiff to prove a bad result in order for the case to go to the jury for its verdict. The jury is then entitled to infer from the bad result that the physician or surgeon was guilty of malpractice. The case to which we refer is *Ales vs. Ryan*, 93 Cal. Dec. 18.

Each of the propositions announced by the Court in *Ales vs. Ryan* is of vital importance to practicing physicians and surgeons. In the present article we will discuss the malpractice responsibility of physicians and surgeons for the negligent conduct of nurses employed by a hospital and assisting in the operating room, since the decision in *Ales vs. Ryan*. In a future article the application of the *res ipsa loquitur* doctrine by the Court will be analyzed.

The full extent of the legal responsibility of surgeons as a consequence of the Supreme Court's opinion in *Ales vs. Ryan* may best be illustrated by repeating the words of the Court itself:

The decisions of this state, when they have spoken on the subject, have endorsed the doctrine that *the surgeon is responsible for the acts of the nurse*. . . . The surgeon had the power, and, therefore, the duty to direct the nurse to count the sponges as part of his work in the opening and closing of plaintiff's abdomen, and putting in and taking out of sponges, and it was his responsibility to see that such work was done. He cannot relieve himself of liability by any custom or rule requiring the nurse to count the sponges used and removed. (Italics supplied.)

It may readily be seen that an operating surgeon in this State is now subject to a malpractice action if any of the nurses in the operating room negligently perform an act or negligently fail to do something which should have been done.

In *Ales vs. Ryan* the surgeon did not own the hospital at which the operation was performed, and the nurses who assisted him were not in his employ. As far as the surgeon knew, a sponge count was made, because a count was reported to him; also, he made an independent search for sponges. It would seem that the surgeon did all that he could in the circumstances. Yet, the Court held him liable for the negligent act of a nurse, the occurrence of which he could not know without neglecting his own duties. As a consequence of the decision in *Ales vs. Ryan*, it may be said that a surgeon is an insurer in so far as the nurses assisting in the operating room are concerned.

A surgeon who is about to undertake a major operation upon a patient in a county hospital might well pause to reflect upon the position in which he is placed by the statutes and decisions in this State, in the event that one of the nurses, employed by the county and delegated to assist him, should, unfortunately, be guilty of a mistake. In the first place, the nurse's employer, the county, cannot even be sued by the patient. In the second place, the operating surgeon is responsible for the nurse's mistake, even if it is of such a nature that he could not have prevented it or remedied it after its occurrence.

In Wyoming the rule is different. The same problem was recently presented to the Supreme Court of that state in the case of *Jackson vs. Hansard*, 17 Pac. (2nd) 659. The Wyoming Court came to the conclusion that an operating surgeon is not entitled to rely exclusively upon the nurse's sponge count, but that he could not be held liable, if he used ordinary care to verify the nurse's count, for example, by an independent investigation.

The principle of law which prevails in Wyoming and in a number of other states is as follows:

While a surgeon performing an operation cannot, ordinarily, be held responsible for the negligence of somebody else, it is his duty, we think, to exercise reasonable care in seeing that no foreign substances which ought to be removed are left in the body, and this duty was in fact, recognized by the defendant in giving his testimony. He should not, we think, ordinarily at least, be able to relieve himself of liability for injury to a patient caused by sponges or pads, by an exclusive reliance on a custom or rule requiring the attendant nurse to count the sponges or pads used and removed, and on his nurse's statement as to the count. On the other hand, he cannot be held responsible for the exercise of more than ordinary care. *He is not an insurer against mishaps*. . . .

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, containing copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

SPECIAL ARTICLES

COCCIDIOIDAL GRANULOMA IN CALIFORNIA IN 1934-1935

Since the publication of Special Bulletin No. 57 by the California State Department of Public Health in 1931 nothing further has been reported on coccidioidal granuloma. This report will serve to revive and bring the data up to date (July 1, 1936).

The general trend of the epidemiology of this disease remains the same as discussed in the Special Bulletin.

Four hundred and fifty cases with two hundred and twenty-four deaths were recorded to July 1, 1936. Table 1 is a tabulation of the cases and deaths by years:

TABLE 1.—*Distribution of Coccidioidal Granuloma in California Cases and Deaths by Years*

Year	Cases	Deaths
Prior to 1928	151	86
1928	36	10
1929	46	25
1930	22	11
1931	19	8
1932	19	9
1933	54	25
1934	49	29
1935	28	14
1936 to July 1	26	7
Totals	450	224

Geographically these cases are distributed according to Table 2. The concentration of cases still persists in central and southern California. Three hundred and one cases, or 66.8 per cent, of the four hundred and fifty cases recorded are from Fresno, Kern, Kings, Tulare, and Los Angeles counties.

The northern rural counties have never reported cases, and it would appear that the disease has certain geographic limits. Since the first large group of cases were reported (prior to 1928) from San Francisco as a medical diagnostic center, only eight cases have been recorded in nine years. Other cases which have been diagnosed in San Francisco have been transferred to the home address or to the most probable source of infection obtained from the detailed history.

A study of the cases according to age and sex (see Table 3) shows that males are the most often affected with 384, or 85 per cent, of the 450 cases occurring in this sex. Sixty-one cases, or 13.3 per cent, are recorded in females and five were of unknown sex. Three cases have been reported under one year of age, and seventeen cases (3.7 per cent) in the one to four age group. However, the majority fall in the higher age groups with a total of 275 cases, or 61 per cent, occurring between the ages of twenty-five and fifty-five years.

TABLE 2.—*Sex and Age*

Age	Male	Female	Unknown	Total
0-1	1	2	...	3
1-4	13	3	1	17
5-9	10	4	...	14
10-14	5	2	...	7
15-19	17	4	...	21
20-24	45	11	...	56
25-34	129	15	...	144
35-44	80	7	...	87
45-54	40	4	...	44
55+	30	8	...	38
A.	13	1	...	14
Unknown	1	...	4	5
Totals	384	61	5	450

Table 4 is a summary of cases according to occupation and sex. The occupations were grouped under the general headings: soil, vegetation, animals, general labor (when no specific type was noted), laboratory infection, and miscellaneous. The latter group included professionals (students) commercial business, mechanical trades, building trades, and others. Two other groups were listed, *i. e.*, unknown occupations and no occupation. Under the heading vegetation was included housewives—since their work brought them into close contact with fruits and vegetables. Seventy-eight patients were found to have work pertaining to the soil; one hundred and one with fruits, vegetables, cotton and other vegetation; one hun-

dred were general laborers; one hundred and sixteen cases were grouped under the miscellaneous heading; twenty-nine were of unknown occupation; and nine had no occupation.

Sixty-five and five-tenths per cent of the cases were found in the groups involving outside work or work involving soil, vegetations, animals, and general outdoor labor. The epidemiology theory that the disease is soil-borne, as expressed by the high percentage of male outdoor workers, has been proved correct since Stewart and Meyer isolated the fungus (*Coccidioides immitis*) from soil samples collected in Kern County.

TABLE 3.—*Occupation*

Type	Male	Female	Unknown	Total
Soil (oil, mines)	78	0	0	78
Vegetation (housework)	64	37	0	101
Animals	16	0	0	16
General laborer	100	0	0	100
Laboratory	1	0	0	1
Miscellaneous:				
Professions and school	21	6	0	27
Children	25	11	1	37
Commercial business	5	1	0	6
Mechanics	19	0	0	19
Building trades	12	0	0	12
Others	12	3	0	15
Unknown occupation	24	1	4	29
No occupation	7	2	0	9
Totals	384	61	5	450

The cases are tabulated in Table 4 according to nationality, with number and percentage given. Practically all races are affected and the per cents for each have remained quite constant since the first tabulation in 1931. There are, however, variations, *i. e.*, the foreign-born whites have decreased slightly, whereas the percentage of cases among Filipinos has doubled during the past five years. The explanation of this increase is not evident from the epidemiological histories. Occupation probably plays a part, as the majority of Filipinos in California are engaged in agricultural work in localities where the highest percentage of cases occurs.

It has been noted that when the medical profession becomes interested in a particular disease, then the morbidity reports increase. This undoubtedly has had an influence on the increase in the number of cases of coccidioidal granuloma reported.

Early diagnosis of pulmonary cases and differential diagnosis from tuberculosis by sputum examination have been important steps during the last few years.

TABLE 4.—*Nationality*

Nationality	Number	Per Cent
American (white)	135	30.00
Mexican	96	21.33
Filipino	67	14.90
Negro	61	13.60
Foreign born (white)	36	8.00
Japanese	9	2.00
Chinese	8	1.80
Portuguese	8	1.80
Hindu	4	.89
Indian	3	.66
East Indian	1	.22
Malayan	2	.44
Unknown	20	4.44
Totals	450	100.00

PRESIDENT'S PERPETUAL BRIDGE TROPHY: LOS ANGELES COUNTY MEDICAL ASSOCIATION

By ARTHUR E. SMITH, M.D., D.D.S.
Los Angeles

During July, 1936, Dr. Harlan Shoemaker, then president of the Los Angeles County Medical Association, appointed a committee, consisting of Doctors S. M. Alter, Charles E. Phillips, and E. Eric Larson, to organize a bridge tournament, to be held at intervals at the Association's headquarters during the remainder of the year. At the end of that time, appropriate prizes were to be given to the winning participants.

The sessions were held every two weeks for ten weeks. About sixty members played at the first session, most of whom continued throughout the whole period.

The players were divided into two sections: the recognized good players were placed in the North and South positions, and those who felt they were not the best of players occupied the East and West positions. At the end of each session the points were tabulated, and there was great rivalry between the members of each section as to their position on the tabulated lists.

Within a short time following the organization of the medical bridge tournament, Doctor Shoemaker came to my office with a copy of the November, 1936, issue of the *National Geographic Magazine*, and approached me, saying, "Arthur, I've got an idea that I want to explain to you. It is my desire to present a prize to the winner of the bridge tournament, and I have been racking my brain to evolve something unusual, something different from the time-worn reward of a cup. I have really remained awake night after night, giving the matter much thought, and at last I conceived the idea of making a trophy, utilizing the *Calendario Azteca* as a support for a miniature bridge game table, chairs and players, and you have been chosen to design and sculpture such a trophy." Doctor Shoemaker was advised that I would consider the production of such a trophy and would confer with him later.

The very next afternoon, however, and before I had considered such a tremendous undertaking, he returned to my office, saying: "I have another idea for the trophy." He explained that he would like to have carved reproductions of the emblematic Mayan feathered serpents, which guard the Temple of Warriors, Chichen Itza, incorporated in the trophy. Inasmuch as I had only read about the feathered serpents, I was bewildered in creating models of them. With the above explanation, Doctor Shoemaker departed, leaving me in amazement with his words, "Now you produce the trophy!" I had nothing to guide me or use—all had to be reproduced, designed and sculptured from photographs that, as yet, we did not have.

It was less than five months until the bridge tournament ended, when the trophy would be presented to the winner. This was a very short space of time to complete such a detailed art production, and I quite realized that midnight oil must be burned if this unique creation were to be born. It was not fully completed the evening it was presented, and since that date many additional hours have been spent to complete it. Approximately four hundred hours were taken in its production.

Much time and effort was necessary to secure the necessary data, photographs, etc., to start the designing and



This photograph of the trophy was taken from above, looking downward, and shows a bridge game in progress. Note the carved *Calendario Azteca*, cards, score pad, pencil, cigarettes, and cigar stand.

modeling. A plaque or copy of the *Calendario Azteca* could not be found in Los Angeles. After wiring a friend in Mexico City, a small picture of the *Calendario* was secured. Books on Mexican art were borrowed from Dr. Elmer A. Belt, which gave considerable data on the *Calendario*, but models or copies of the feathered serpents could be located in Los Angeles. Some books were secured from the Public Library which gave data and history of the feathered serpents; and after considerable study it was decided that the trophy should consist of four distinct parts: a base designed from Mayan steps leading to Caracol; six legs of feathered serpent design; a disk to support the tableau designed from the *Calendario Azteca*, and a tableau depicting an actual scene during a game of bridge.

After obtaining the above-mentioned data, the next step was to decide on the size of the trophy. The size of the players in miniature, bridge table, chairs, etc., had to be considered from the standpoint of sculpturing. A one-eighth to one-inch scale was decided upon.

The first step in production was to make the *Calendario*. A photograph was taken from the illustration sent from Mexico City, and then an eighteen-inch enlargement was made, and after that an eighteen-inch copper disk, upon which, with scribing tools, the hieroglyphics from the photograph of the *Calendario* were outlined in minute detail. When this was completed, an impression was taken and a plastic positive model produced; then the detailed outline of the hieroglyphics of the *Calendario* were reproduced upon the positive plastic model. That done, all the characters were carefully carved in relief. When this was completed, another negative impression was made from which a positive model was produced in artificial marble. (All models comprising the trophy were reproduced in copper and bronze before assembling.)

The next step was to create models of the feathered serpents. Having no model as a guide, we photographed the feathered serpent from the November, 1936, issue of the *National Geographic Magazine*. This photograph was enlarged to the desired size and was used as a guide in carving a model in plastic material. At the completion of the original, impressions were taken and six reproductions were cast in artificial marble which were reproduced later in bronze. These six feathered serpent copies were to support the *Calendario* and tableau.

For production of the tableau, I photographed four players seated at a bridge table, in informal pose while a bridge game was in session. The players—Doctors Harlan Shoemaker, Charles E. Phillips, Edward C. Pallette, and E. Eric Larson—were photographed from four



The above photograph shows a close-up view of the trophy. Note the base of Mayan design and the six feathered serpent columns supporting the *Calendario Azteca* upon which rests the tableau.

different angles, and each was modeled to scale in clay in his original position. When the players were sculptured, impressions were taken of each miniature and reproductions made in artificial marble and later in bronze. The players were placed in their respective chairs in the exact position that they occupied during the actual bridge game. The score pad, pencil, cigarettes, and pipe were produced in metal on a one-eighth to one-inch scale.

The next step was to produce the bridge table, chairs, and cigar stands. I now conferred with Mr. Cochems, Executive Secretary of the Association, and secured a bridge table, chair, and cigar stand, which were photographed with the players. This equipment was used for the production of the miniature models. Careful measurements were taken and the miniature models were accurately made on a one-eighth to one-inch ratio, from brass and copper. The playing cards were individually cut from thin spring brass, to scale, by the use of a template.

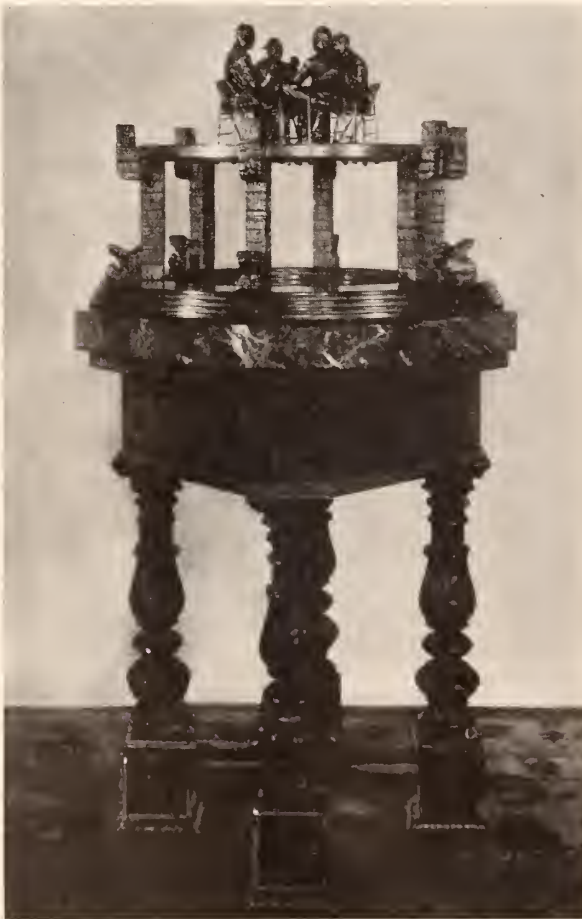
The table, chairs, cigar stands, cards, cigarettes, and the players were now assembled. The next step was to attach the six supporting feathered serpent columns to the Calendario Azteca. These columns occupy equidistant positions. The base, which supports the feathered serpent columns, the Calendario Azteca, and the tableau, is of Mayan design and was created from a photograph of the stone steps leading to the entrance of the Caracol, Chichen Itza. After complete assemblage of the various parts, which comprise the trophy, it was reproduced in copper and bronze.

It will be noted that Doctor Palette and Doctor Phillips each hold twelve cards; Doctor Shoemaker holds thirteen, and is about to play, while Doctor Larson has spread his cards upon the table.

It will also be observed that Doctor Larson is holding a cigarette between his fingers and is peering very serenely



Calendario Azteca shown in detail. This forms the support for the miniature bridge table and players of the President's Trophy.



This photograph displays the trophy at a distance. Note the open mouths of the feathered serpents, and the carved columns.

through his Harold Lloyd spectacles, with his "britches" pulled up almost to his knees. It will be noted that the expression on Doctor Shoemaker's face is that of deep thought and anxiety to win. Doctor Palette's cigarette is reposing on the edge of the table and, as usual, his right leg is resting against his abdomen. Doctor Phillips appears nonchalant and is sucking on an old strong pipe, which has been in use for at least twenty years.

A banquet was served on December 23, 1936, after the sessions were completed, and prizes were awarded to the top four players in each section. All prizes, except the honor prize, were given by different firms dealing in medical supplies.

The honor prize was presented by the writer with the following understanding: (1) It is to be known as the President's Perpetual Bridge Trophy. (2) It is to be the property of the Los Angeles County Medical Association. (3) It is to remain on display at the Association's headquarters. (4) The trophy is to be awarded each year to the physician who makes the highest bridge points and his name shall be placed thereon.

The winner for 1936 was Dr. Harold P. Hare, whose name is the first to be engraved upon the trophy.

A description of the Aztec zone is given in the encyclopedias and other volumes. . . .

The following inscription on copper is attached to the trophy:

THE PRESIDENT'S PERPETUAL BRIDGE TROPHY
Suggested by Harlan Shoemaker, M.D.

President, Los Angeles County Medical Association, 1936
Reproduced and Sculptured From Photographs

by

Arthur E. Smith, M.D., D.D.S.

The disc of the trophy, upon which tableau rests, is a carved reproduction of the Calendario Azteca. The original is in the museum in Mexico City. It is supported by six carved reproductions of the Mayan feathered serpents, the originals of which guard the Temple of Warriors, in Chichen Itza

North—Charles E. Phillips, M.D.

South—E. Eric Larson, M.D.

East—Edward C. Palette, M.D.

West—Harlan Shoemaker, M.D.

1930 Wilshire Boulevard.

SOCIAL HYGIENE—1937 MODEL

Some Last Year's Events Which Have Helped to Build the Framework for the Coming Year

The whole history of social hygiene is living drama, from the days of Moses' law-giving down to the present sweeping drive for syphilis control, but surely no period has seen more dramatic events and rapid developments than the past twelve months. This has been particularly true as regards public knowledge and coöperation in the campaign against the venereal diseases. At the beginning of 1936 the situation in this respect was much the same as at any time since the World War impetus slackened its force. Comparatively few people recognized syphilis and gonorrhea as widespread infectious diseases. The social hygiene societies and other health agencies battered against a wall of secrecy and indifference which successfully hid the real facts. The great multitude remained unaware of this threat to family and community health, nor knew what to do if the threat became a reality. Many, as always, were suffering the results of their lack of knowledge, without hope for future recovery.

Contrast with that shadowed picture the brilliant scene as the year closed, with health officials and social hygiene executives meeting in Washington at the invitation of Surgeon-General Parran and with the benediction of President Roosevelt, to map a nation-wide fight against syphilis, and asking for \$25,000,000 to provide the sinews of war. Newspapers and news magazines hailed this conference as one of the most important ever held in the United States—gave it front-page space—wrote leading editorials of approving comment. Many of them had been crusading all through the year for such objectives. The thousand conferees, returning to the country's four corners, found that the home folks had kept pace with Washington happenings, knew what was going on. People were reading and talking about syphilis and how to avoid it. More sick people were seeking treatment. Town authorities were appropriating funds for clinics for those who could not afford to pay doctors. All were ready to help conquer this ancient enemy, now smoked out of ambush. Truly, a marvelous change in public attitude to come about in one short year.

What brought about this change? What happened in 1936 to lift the fog of public apathy and indifference, and promise continuing recognition to social hygiene as a vital issue in present-day life? Passing the year's events in review, we note a few "peaks of progress":

Surgeon-General Parran's announced determination to make the prevention and control of syphilis a major objective of the United States Public Health survey program, and the practical efforts of himself and his staff to find ways and means to this end, as witness the "Christmas Conference" mentioned above.

The passage of the Social Security Act, with the provision of funds applicable to venereal disease control through the state and city departments of health, and the resultant developing of new and effective programs in important localities.

The great increase in newspaper coöperation in social hygiene education of the public, led off by special series of articles published by the Chicago Sunday Tribune and the New York Daily News, and the Washington Herald, and followed in the course of the year by similar feature articles in other important newspapers across the country. A few are: the Portland Oregonian, San Francisco News, Los Angeles Evening News, Philadelphia News, St. Louis Post Dispatch, Dallas News, Buffalo Times, and Syracuse Post-Standard. Aside from these special features, news items and editorials are frequent and informative. Metropolitan dailies, including the New York Times, New York Herald-Tribune, World-Telegram, Evening Post, Sun, the Brooklyn Eagle, and others, which have been accustomed to speak more or less frankly for some time, have increased their coöperation and are definitely influencing public opinion by thoughtful editorials. Many newspapers in smaller communities, such as the Winston-Salem (N. C.) Observer and Evanston (Ill.) News-Index, are actively crusading for the establishment or improvement of local treatment facilities.

The similar increase in interest and practical educational help shown by the weekly and monthly standard maga-

zines. Doctor Parran's fine article, "Why Don't We Stamp Out Syphilis," appearing in the July Survey Graphic, and condensed in the July Reader's Digest, set a new high for reader interest and continued distribution. Seven months after these articles appeared, the publishers and the Association have constant call for reprints, the Digest reporting to date a total distribution of nearly 400,000 to all parts of the world. Recent articles in the Literary Digest, Time, News-Week, and other weeklies, are familiar to all, as are the frequent mentions in home magazines like Ladies' Home Journal, Woman's Home Companion, Farmer's Wife, and Pictorial Review. Liberty has published a number of editorials. Physical Culture ran a series of four special articles during the year. Magazines with special articles in preparation for early 1937 publication include The New York Woman, The Forum, Parents' Magazine, and others. Semi-professional publications such as the National Parent-Teacher, the Junior League Magazine, and Hygeia, have published several articles. The many articles in medical journals, publications for nurses and for other professional and technical groups, have indirectly been of great value in promoting public knowledge and interest during the year.

The increased coöperation of large membership groups such as the General Federation of Women's Clubs and the National Council of Women, whose public health committees during 1936 developed definite programs for club coöperation in syphilis control will enlist the interest and effort of millions of women.

The renewed educational efforts of the Metropolitan Life Insurance Company, which during 1936 prepared for publication (in February, 1937) for the third time a statement concerning syphilis, as one of its regular monthly series of full-page magazine advertisements and distributed thousands of reprints of this advertisement and of a new edition of the pamphlet "The Great Imitator," already widely circulated.

The production of the new "talking slide film" "For All Our Sakes," dealing with syphilis, under the sponsorship of the United States Public Health Service and the Association, and the purchase and showing of this production by a large number of health officers and agencies, mercantile, industrial and other concerns among employees and the lay public.

Publication of the report of the Committee on Survey of Research on the Gonococcus and Gonococcal Infections by the National Research Council and the Association, and a resultant quickening of interest in the possibilities of doing for this prevalent and serious disease as much as has been done for syphilis.

The holding of the fourth annual New York Regional Conference in January, with 2,500 people attending; similar meetings in Syracuse, Buffalo, Rochester, held by local social hygiene committees last fall; Social Hygiene Week, November 1 to 7, sponsored by the Missouri Social Hygiene Association; the month-long educational campaign conducted by the Erie Social Hygiene Association in November and December. Dozens of other conferences, meetings, and sessions held all over the country, by state and local groups and national agencies such as the American Medical Association, the National Conference of Social Work, the American Public Health Association, and the American Hospital Association.

The establishment of numerous new social hygiene committees or societies during 1936, among them:

California—Southern California Association for the Study and Prevention of Syphilis and Gonorrhea, Los Angeles.

Illinois—Social Hygiene Committee, Robinson; Social Hygiene Committee, Council of Social Agencies, Rock Island.

New Jersey—Institute on Marriage and the Home, East Orange.

New York—Social Hygiene Committee, Chautauqua County Tuberculosis and Health Association, Dunkirk; Club for Prevention of Venereal Disease, Middletown.

Ohio—Social Hygiene Committee, Cleveland Health Council, Cleveland.

Washington—Social Hygiene Committee, Tacoma Public Health Council, Tacoma.

These are but a few glimpses of a swiftly moving procession of events, each of which we believe has had its effect in bringing about the great increase noted in public interest and information, and in creating the present favorable outlook for further progress during 1937. Many other factors were involved. A particularly fortunate set of circumstances combined to open the way for these activities, and behind these were years of hard work by all concerned with family health and welfare to bring about just such circumstances, and direction and purpose and planning which enable the wise use of the fortunate situation when it finally occurred. To the leaders and workers who have for long devoted their thought and labor to attack on the barriers of silence and ignorance which, we may hope, are now definitely beginning to break down, belong the praise and the credit and the gratitude of posterity. And in the exultation of the moment over the possibility of actually conquering syphilis at last, it is not forgotten that other phases of the social hygiene program—among them education for marriage and parenthood, the repression of prostitution, and the prevention of sex delinquency—have played and must continue to play, an important part in the programs and benefits of the future.

As the agency serving as a national clearing house, the Association and its staff as workers in the ranks, take pleasure in presenting this brief review, and in behalf of the social hygiene societies and the communities for which they labor, we thank all who have helped in any way in the year's progress, and bespeak their coöperation in the days to come.*

"AMATEUR" AND BRANCH NIGHT

Los Angeles County Medical Association Institutes Unique Entertainment Feature

Standing room only! Everybody was out to see colleagues "do their stuff."

Amateur and Branch Night at the Los Angeles County Medical Association on Thursday evening, March 4, packed the Lounge.

This unique evening of entertainment, which brought many members of the branches and their families to the Association, began with a dinner in the Association headquarters, at which there were 160 guests.

Following the dinner the president, Dr. John P. Nuttall, introduced the master of ceremonies for the evening, Dr. D. G. Tollefson. Much credit goes to Doctor Tollefson and his physician associates who took part in the program, and who were responsible for making the evening a great success.

Doctor Tollefson, as a preliminary and unannounced skit, called upon the secretaries of the branches to answer certain questions relative to those parts of Los Angeles County in which their respective branches functioned. Some of these were pertinent and humorous questions. The secretaries, however, faced the ordeal without flinching, and some came through victorious. The "talent display" from the various geographical branches was then brought forward.

First was the presentation of the Alhambra branch: Doctor Eugene S. Maxson's rendition of two poems by Kipling—"Gunga Din" and "Boots"—winning much applause.

Dr. Marvel Beem of Santa Monica—Doctor Beem, by the way, has a splendid voice—opened the program for the Santa Monica branch with songs of the type that Lawrence Tibbett likes to sing. Dr. R. J. Morrison's impersonation of Harry Lauder—costume, coughs, cane and all—was fine entertainment. Dr. John Bergmann, the accompanist, completed the Santa Monica act.

The Pasadena branch for years has been hiding the ability of its professional men in ballet technique. Ballet costumes are intriguing on the male form. They created a picture filled with movement and of beauty that certainly never could have been imagined by anyone who was not fortunate enough to see it. So graceful was their interpretation of a difficult Russian dance that they were

presented with a gorgeous vegetable bouquet, which expressed the appreciation of some of their admirers. Doctors Robert K. Gustafson, Lyle G. Craig, Ralph E. Netzley, and Russell M. Decker made up the ballet, the accompanist being Doctor Decker.

Because Amateur Night happened to fall upon the same night as the Speakers' Bureau, the Master of Ceremonies called for remarks from the Speakers' Bureau, pertinent to the work of that Bureau.

Dr. H. O. Barnes, scheduled for a talk at the Speakers' Bureau meeting, must be given credit for arising to a very difficult situation when he was called upon by the Master of Ceremonies to give his talk. Doctor Barnes in doing this set an example for all who aspire to address public gatherings. To be a good speaker, one must be prepared, of course, at all times, to get on one's feet, and even when the spirit that surrounds one is of levity, to be able to command attention—this Doctor Barnes did.

Doctors George B. Kryder, S. H. Welch, F. E. Poole, Fred W. Loring, Orrie Christ, and William M. Gibbs made up the Glendale troupe, announced as the "Choral Society of Glendale," otherwise known as the "Disturb-ers." To describe this act one has to use the term "burlesque." The theme of the show was a sponsored radio broadcast.

Dr. Clinton D. Hubbard of Huntington Park mystified the audience by pulling white rabbits out of hats, and other feats of magic. Much applause greeted this presentation of the southeast branch.

From Pomona came a male quartet: Doctors H. C. Anderson, C. A. Arneson, C. W. White, M. R. Jones, and Elwin Welch, in blackface. Good voices all and fine entertainment.

Long Beach, one of the largest branches, depended upon only two of its members to uphold the honors of that branch. But the Branch had reason for its confidence in these two doctors—Raymond Swinney and R. T. Uhls. The act opened with the singing of "Frankie and Johnny," with guitar accompaniment by Doctor Uhls. The setting was of an older time in a small town in Iowa and a medicine show. Doctor Swinney, as Dr. I. Curem, gave a most realistic portrayal of the old-time Medicine Man exhorting "Bray-zilian Oil" and cure-alls of various types for the cure of man and beasts. Yes, this was an act.

Nearly four hundred members attended the show. It was one of the biggest gatherings at the Association since the opening of the headquarters building several years ago.

EXPERT WITNESSES*

By EDWARD C. KRAUSS

The old controversy about expert witnesses has been revived by the publication, CALIFORNIA AND WESTERN MEDICINE, with a brand-new suggestion—that members of the medical profession refuse to testify as experts unless appointed by the Court.

California law provides for the appointment of experts by the Court for both civil and criminal cases, but also permits the testimony of experts hired by either or both sides. The courts have frequently used the power to appoint experts in criminal cases, but they rarely appear in civil cases; with the result that personal injury suits, in particular, seem to be battles between groups of experts open to the suspicion of being partisans of either plaintiff or defendant.

No self-respecting medical man wants to be put in this position, say Doctors H. D. Barnard and George E. Tucker in the publication referred to, but there is no agreement as to how the situation can be avoided. The suggestion that they decline to appear except when appointed by the Court is made by Dr. Andrew S. Lobingier, who originally suggested the present California statute permitting court appointment.

The law provides all that is needed, in the opinion of Doctor Lobingier; what is at fault is the apathy of judges in exercising their privilege. But if the judges will not act, the medical men can, since there is no compulsion upon experts to give testimony. A witness may be re-

* From the American Social Hygiene Association.

* Editorial, Los Angeles Times, March 3, 1937.

quired to testify as to facts, but expert witnesses give opinions, not facts.

The belief that in many cases expert testimony is a purchasable commodity, is possibly only too well grounded, and the California statute providing for naming of disinterested experts by the trial court, plus Doctor Lobinger's suggestion, seems to offer a practicable way out.

If the medical profession adopts this suggestion, it will lead the way in a general housecleaning of the expert-witness field. It is a place in which reform is unquestionably needed.

SYNOPSIS OF MALPRACTICE

By WILLIAM M. RAINS, LL.B.*
Los Angeles

(With apologies to H. L. Tidy, M. D., and his celebrated "Synopsis of Medicine.")

(*Tic doulouerror*) (*Bury-Bury*) (*Mistake*)

MALPRACTICE

An acute infectious disease transmissible mainly to physicians and surgeons, only by the excreta of former patients, characterized by severe pain and prolonged sequelae. Rarely fatal.

Etiology.—Virus unknown, principally affects busy doctors; ultra-careful and conservative practitioners not immune. Endemic throughout North America, particularly United States of America. Degree of infectivity high when exposed to carriers of bacillus avaritia.

Symptoms.—(a) Incubation period: One year from exposure, sometimes called "Statute of Limitations."

(b) Premonitory period: Usually two to eleven months, crystallized by sudden chill upon contact with patient, ordinarily in connection with latter's simulated bill-uselessness.

(c) Clinical period and eruption: Generally during last days of incubation period coincident with premature, too radical treatment of patient's neglect to pay bill.

Characteristics of Clinical Stage.—(a) Eruptions, asymmetrical and varicoid, but always identifiable by court summons and complaint and invariably accompanied by a pimply rash in the form of a process server.

(b) Excruciating hyperesthesia in the region of the gluteus maximus, and splenius colli. Also frequently red spots before the eyes, and set teeth on edge.

Chronic Stage.—May continue six months to five years. A pyrexia syndrome occurs during this stage if the disease is at all activated, the culmination of the febrile parabola always manifesting itself in direct relation to the time of appearance of the "victim" in a court proceeding.

Course and Prognosis.—If early treatment can be obtained, the uncomplicated disease usually smothers in its own excreta. The prognosis is markedly good if there has been a generally effective starvation of the "bacillus avaritia."

Prophylaxis.—(1) Do not (unless necessary) sue for fees until one year has elapsed from the date of last treatment. Patients ordinarily have only one year within which to sue for malpractice. Doctors have at least two years within which to sue for fees. If patient is a minor, the rule is different; consult counsel.

(2) Pay or no pay, a private physician is equally responsible in law, therefore, insist on coöperation of the patient in all reasonably required respects, such as x-rays and laboratory analyses; otherwise demand acceptance of public facilities and release of responsibility.

(3) Do not criticize the doctor who precedes on a case. The problem may have appeared distinctly or subtly different to him. Remember, if your successor follows this paragraph faithfully, your sincerest though perhaps most futile efforts will be accounted sympathetically.

(4) Do not experiment on a live patient. Risks likely to be dangerous to a patient provoked by experiment are incompatible with the law. Therefore, to avoid legal responsibility for damage, refrain from doing that which the ordinarily prudent practitioner of average skill would not

do under similar circumstances, and be diligent to do at least those things which a reasonably prudent practitioner would consider indicated under similar circumstances.

If this rule is followed, bad results do not support legal responsibility.

(5) Do not be brutal. "Offensiveness" is *not* the best "defense" to impending trouble with a patient. On the contrary, kindness, solicitude, understanding, and, surprisingly often, consultation will ward off lurking trouble.

Treatment.—(a) Aromatic spirits, care, and caution 1 oz. t. i. d., p. c.

(b) Sweet oil of charity q. s. for articulating surfaces with other doctors.

(c) Isolation of case records and x-rays.

(d) Absolute quiet, abstention from further exposure to source of infection or carrier.

(e) When examined in court be frank, modest, sympathetic, professional. Avoid inclinations to rancor or debate. (Let counsel carry latter burdens.)

Morbid Anatomy.—Though this disease is only rarely fatal, there is one outstanding histologic sequela, to wit: Proliferation and desquamation of the cortex of the "glans reputation."

Thus, it is well to follow the prophylactic admonitions wherever possible if this unfortunate result is to be avoided to yourself or your fellow practitioner.

THE PAY-PATIENT PLAN SHOULD NOT BE APPROVED*

An assembly committee has tabled a bill by Assemblyman S. L. Heisinger of Fresno County, seeking to amend the Political Code to open the doors of county hospitals to "pay" patients on permission of the county supervisors.

That was a good move.

Sacramento County once had such a system. But when the new county charter was adopted it was abolished, because experience had shown it to be limited to individual benefits, but *costly to the taxpayers*.

To get rid of the abuses developed thereunder, the county charter specifically provides:

The Sacramento County Hospital shall be maintained for Sacramento County indigents only.

1 1 1

On July 1 of this year this system will have been in operation for a period of four years. Suggestions have been made from time to time that it be modified—most of them brought forward by interested office holders—but they have failed to gain any appreciable support from the public.

The reason is obvious.

The people have found the present *modus operandi* satisfactory and at the same time *they have not been called on to contribute large amounts in taxes to pay for medical attention and hospital care for those well able to provide for themselves otherwise*.

1 1 1

What is the aim and purpose of a county hospital?

It is to see to it that the unfortunate and the needy are not denied medical service; that they shall not die or suffer needlessly because they do not have the means to pay for medical or hospital care.

The people are perfectly willing to supply through taxation sufficient money to support such institutions. But they are not in favor of county hospitals whose doors will be thrown open to those with political influence and pull on the "pay" theory. Experience has shown that such "pay" is more often than not a delusion—a promise seldom expected to be fulfilled.

The Legislature will do well to leave the final decision of the policy in such matters to the counties themselves.

* Member of the Los Angeles Bar.

*From the Sacramento Bee. An editorial in March 15, 1937, issue.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. X, No. 4, April, 1912

From Some Editorial Notes:

Record Your Certificate.—To practice medicine legally in this State you must first get a license from the State Board of Medical Examiners and then have that license, or certificate, recorded in the county in which you reside and practice. The recording of the license is made as much a part of the law as the getting of it, and it is just as important. The Board of Examiners has found that this provision of the law has been very generally overlooked by a considerable number of physicians. . . .

Another Why?—Last month the JOURNAL published some editorial notes relating to distinguished physicians who had contributed articles to publications which continue to advertise nostrums and frauds that have been shown up. These remarks have created some little comment which, so far as it has come to the attention of the JOURNAL, has been entirely favorable. We shall continue to refer to the subject from time to time. In the *American Journal of Urology* for February, 1912, there is an article by Dr. ———, a distinguished physician of San Francisco and for many years a prominent member of our Society. In the same issue of that medical (?) journal are to be found the following advertisements: ergoapiol, antiphlogistine, glycothymoline, peptomangan, glycoheroin, antheol, and dioradin. The list is not so large as some, but that is probably because the publication is a special one and, doubtless, has but a limited circulation. Does Dr. ——— know anything about the things that that journal advertises? . . .

Hydrophobia.—Interest in rabies has been greatly intensified by its suddenly becoming prevalent in San Francisco. During the month of February many dogs developed the characteristic symptoms and a number of human beings were bitten. Proof of the presence of rabies was secured in many cases by the demonstration of Negri bodies in the ganglion cells of the brain tissue, and in some instances by the production of the disease in laboratory animals, through inoculation. The examinations were made in the State Hygienic Laboratory in Berkeley, in the laboratory of the San Francisco Health Department, and in the laboratory of the Letterman General Hospital at the Presidio.

The State Board of Health has done much to minimize the number of human deaths by providing Pasteur treatment with United States Government virus for the people who have been bitten by rabid animals and are unable to be immunized at their own expense. . . .

From an Article on "The Life of Radium and Its Therapeutic Use in Internal Medicine" by E. O. Jellinek, M. D., San Francisco.—You remember, that if you force a sufficient electric current through the so-called Crookes tube that this tube will display some characteristic light effects around the anode and the cathode. As the light effects displayed around the cathode are the only ones which have any bearing on the subject which we intend to investigate tonight, I will ask your permission to recall in a few words the phenomena displaying themselves around this terminal. . . .

From an Article on "A General Consideration of Some Points of Interest in the Diagnosis and Treatment of Syphilis" by George D. Culver, M. D., San Francisco.—Schaudinn and Hoffman's discovery of the Spirocheta pallida, Wassermann's application of the complement—

(Continued in Front Advertising Section, Page 17)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

News

"Alleging that [I.] Jesse Citron, Hemet physician, retarded his recovery when he was ill with pneumonia last summer and that \$12,000 is not a 'reasonable and proper' fee for medical services, W. C. Fields, screen comedian, last Friday filed a countercomplaint against the physician, asking \$25,000 damages. Doctor Citron seeks to collect \$12,000 through the courts for medical services said to have been rendered the film star during his illness. According to the cross complaint filed by the screen star in Riverside County Court, Doctor Citron 'wilfully treated the defendant in such a way as materially to retard the recovery of defendant; that plaintiff administered certain drugs and medicines to defendant which plaintiff well knew would retard recovery' of Fields. . . . Filed on January 11, the plaintiff's original complaint maintained he had labored twenty-five days and nights continuously and had 'completely cured' the actor. For such services the \$12,000 was declared a 'reasonable' fee. . . ." (*Hemet News*, February 26, 1937.)

"Al Williams, who advertises himself as a 'Conditioner of Men' at his offices in the Spring Arcade Building, overstepped bounds when he made actual medical diagnoses, according to charges yesterday in Municipal Judge Arthur Guerin's court. Williams went on trial accused of violating the State Medical Practice Act. Andrew Anagnos, bank clerk, testified Williams told him he was suffering from high blood pressure and could cure him in three months with three treatments a week for \$200. Anagnos paid Williams \$50, took nine treatments and was 'all tired out.' John Ronan, Inspector for the State Medical Board, testified Williams diagnosed his condition as serious, asserting he was suffering from heart disease. Ronan claims physicians state he is in perfect health." (*Los Angeles Illustrated Daily News*, March 6, 1937.) Acting Special Agent Ronan reported that following a jury trial, Al Williams was found guilty March 8, whereupon motion for a new trial was filed.

Our Investigation Department reports that J. Bruce Clark, D. C., said to be an office associate of Al Williams, on February 2, 1937, pleaded guilty to a charge of violation of the Chiropractic Act and on February 9 was sentenced to pay a fine of \$100 or serve fifty days in the city jail, the sentence being suspended and defendant placed on probation for one year.

"Dr. Jacques P. Gray, First Assistant Director of Public Health in San Francisco for the past seven years, will leave the San Francisco department early in April. He will accept a dual position of principal health officer and manager of the Angeline Elizabeth Kirby Memorial Health Center in Wilkesbarre, Pennsylvania. . . ." (*San Francisco Examiner*, March 9, 1937.)

"Superior Judge M. C. Glenn today upheld the right of the State Board of Medical Examiners to cancel the license of a physician for performing an illegal operation. Judge Glenn denied the petition for a writ of review, which was filed by Dr. George W. O'Donnell, San Francisco physician, who sought to annul the Board's order canceling his license." (*Associated Press dispatch*, dated Sacramento, March 2, and printed in the *Oakland Tribune*, March 2, 1937.)

(Continued in Front Advertising Section, Page 17)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.



BAXTER'S ARE THE PIONEER SOLUTIONS

In every page of history, in every conquest of science or geography or medicine there will be found a pioneer.

A pioneer, with imagination to conceive—with determination to do—with ability to execute—with vision to plan.

Baxter is the pioneer in the development of commercial ready-to-use solutions. Baxter developed intravenous solutions to a high point of perfection, then developed the incomparable Vacoliter — Baxter's dispensing container for intravenous solutions.

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260 Montgomery Street

Federal Courts Fine Thirty Food and Drug Shippers.—Thirty criminal actions brought under the Federal Food and Drugs Act were recently cleared through the federal courts, the Food and Drug Administration states in summarizing its activities for that month. The cases, involving many violations uncovered by the Administration's inspectors during the past year, resulted in a wide range of penalties, the size of which is within the discretion of the courts up to the maximum set by the terms of the law.

Seven west coast fish canners found guilty of shipping canned fish, some of which was in part decomposed, also were fined during January. Those shipping salmon and their fines: G. P. Halferty & Co., Seattle, Washington, \$10; Point Roberts Packers, Inc., Point Roberts, Washington, \$11; Pioneer Canneries, Inc., Seattle Washington, \$12.50; Lighthouse Packing Co., Point Roberts, Washington, \$24; Uganik Fisheries, Uganik, Alaska, and

(Continued on Page 36)

Announcing...

PROTAMINE ZINC INSULIN, *Squibb*



Hagedorn, Jensen, Krarup and Wodstrup-Nielsen of Copenhagen reported, in 1935, that by addition of protamine to aqueous solutions of the active anti-diabetic principle they had succeeded in obtaining a modified, precipitated preparation having an effect much more prolonged than that of unmodified Insulin. Later it was demonstrated, at the University of Toronto, that by adding a small amount of zinc to a preparation of Insulin and protamine, both the stability of the preparation and the duration of its blood-sugar-lowering effect could be increased. These findings have led to the evolution of a product now designated Protamine Zinc Insulin. This product has been given extensive clinical trial and signifies a distinct advance in treatment of diabetes mellitus.

ADVANTAGES OF PROTAMINE ZINC INSULIN

1—The duration of action of a single dose is from about three to six times that of unmodified Insulin.

2—Hypoglycemic reactions both in children and in adults are not so frequent as those following use of unmodified Insulin. The incidence of ketosis is markedly reduced.

3—Results suggest that a somewhat less rigid dietary regimen, and an ample carbohydrate allowance may be permissible.

4—For most patients receiving the product, one injection a day is adequate.

5—Lessening of fluctuations in blood-sugar levels has a favorable effect upon patients' sense of well-being.

PROTAMINE ZINC INSULIN, *Squibb* complies with the rigid specifications of the Insulin Committee, University of Toronto, under whose control it is manufactured and supplied. It is available in 10-cc. vials. When this preparation is brought into uniform suspension, each cc. contains 40 units of Insulin together with protamine and approximately 0.08 mg. of zinc.

E·R·SQUIBB & SONS, NEW YORK
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.

CALSO WATER

Palatable **ALKALINE** *Sparkling*

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Calso Water: An efficient method of supplying the normal ALKALINE SALTS for counteracting ACIDOSIS.

Calso Water: Made of distilled water and the ALKALINE SALTS (C. P.) normally present in the healthy body.

Calso Water: Counteracts and prevents ACIDOSIS, maintains the ALKALINE RESERVE.

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FRANKLIN HOSPITAL

Limited General Hospital with accommodations for 220 patients, located in a seven-acre Park, 14th and Noe streets, San Francisco.

Founded in 1852

The Franklin Hospital is offering hospitalization on a periodic payment plan, with the patient having free choice of physician.

WALTER V. ROHLFFS, Ph. D.
President

LeROY BROOKS, M. D.
Chief of Staff

FRANK SCHMIDT
Superintendent

(Continued from Page 34)

Seattle, Washington, \$25; and Alaska Year Round Canneries Co., Seattle, Washington, \$150. For shipping canned tuna fish in part decomposed, the Sun Harbor Packing Corporation, San Diego, California, was fined \$600. In all cases except the last, court costs in addition were assessed.

Drug Cases Terminated

The following terminations were entered in drug cases: Tricasco Laboratories, Chicago, Illinois, "Tricasco," a syrup containing licorice and plant extracts, offered for the treatment of fifty diseases and abnormal conditions of the stomach, intestines, liver, kidneys, and gall-bladder, fine \$25; Winfield R. Offutt and United Distributors, Inc., Louisville, Kentucky, "Wittone," essentially a colored and flavored solution of Epsom salt, for indigestion, coated tongue, headache, chronic malaria, rheumatism pains, impure blood, tired, dull, weak feeling, influenza, dysentery, bloody flux, and cholera infantum, fine \$30 against each defendant (\$60 in all); Kirby's Mineral Products (Hydrick L. and Frank O. Kirby), "Kirby's Miracle Mineral, a water solution of iron sulfate offered for the treatment of fifty serious disease conditions, including skin diseases, diabetes, rheumatism, pyorrhea, and venereal diseases," fines totaling \$250.

For drug preparations not conforming to the official standards or to the claims of composition made on labels, these were fined as follows: James Good, Philadelphia, Pennsylvania, \$500; Battle & Co., Chemists Corporation, St. Louis, Missouri, \$550 and costs; William H. Rorer, Inc., Philadelphia, Pennsylvania, \$10; Abbott Laboratories, North Chicago, Illinois, \$25; Chicago Pharmacal Co., Chicago, Illinois, \$50 and costs; National Drug Co., Philadelphia, Pennsylvania, \$50; and Boyle & Co., Los Angeles, California, \$600.

Drug Products Seized

Drug products seized during January included 330 gallons of substandard cod-liver oil, 250 bottles of substandard

(Continued on Page 38)

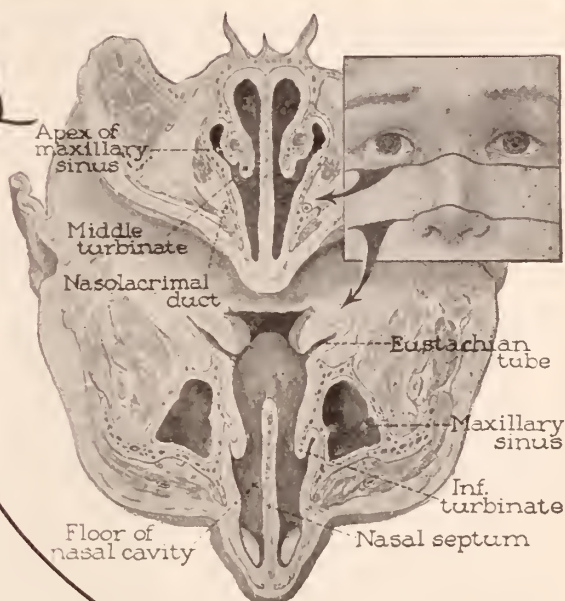
NEO-SYNEPHRIN

HYDROCHLORIDE

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*in Children's
Colds*

● A few drops of Neo-Synephrin Hydrochloride applied in each nostril will greatly relieve the discomfort of the infant or child suffering from the common cold, sinusitis or rhinitis.



ADVANTAGES:

- No sting
- Less toxic in therapeutic dosage than epinephrine or ephedrine
- Active on repeated administration
- Relatively stable
- More sustained in action than epinephrine

SUPPLIED IN **3** FORMS:

NEO-SYNEPHRIN HYDROCHLORIDE **SOLUTION**

1/4% & 1% (1-oz. bottles)

NEO-SYNEPHRIN HYDROCHLORIDE **EMULSION**

1/4% (1-oz. bottles)

NEO-SYNEPHRIN HYDROCHLORIDE **JELLY**

1/2% (in collapsible tubes with nasal applicator)



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When you refer a patient to M. J. Benjamin you are assured that a support will be carefully made according to sound principles backed by two generations of experience.

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THE LONDON LANCET says: "There are two spots in the world with the most equable climate. One is Assuan, Egypt, the other is a little town in the foothills of the Santa Cruz Mountains in California, called Los Gatos."

Rates, Information and Booklet on Request

(Continued from Page 36)

and aromatic spirits of ammonia, one lot of ampoules of iron and arsenic, ampoules of iron, arsenic and phosphorus, and ampoules of glycerophosphates compound, showing shortages in the principal ingredients; 1,136 packages of unsterile gauze bandage, 87 packages of unsterile adhesive plaster.

Potent medicines seized included "Cal-O-San Stomach Tablets," made of bismuth subcarbonate, calcium and sodium bicarbonate, starch and peppermint, falsely offered as a treatment for stomach ulcers; "G. W. Davis Inflammatory Extirpator," containing 69 per cent alcohol, capsicum, volatile oils including turpentine, camphor, gum and water, for coughs, sore throat, diarrhea, chills, bilious colic, cholera morbus, urinary diseases, neuralgia, dyspepsia, grippe, toothache, piles, sores of all kinds, rheumatism, asthma, general debility, indigestion, sour stomach, loss of appetite, nervous headache, earache, dysentery, inflamed or weak eyes, croup, prolapsus uteri and cramps (the further charge was made that the alcohol declaration required by law was inconspicuously placed on the label).

"Elco-Rub," a petrolatum with eucalyptus, wintergreen, camphor, menthol, turpentine, and guaiacol, for persistent cough, sore throat, whooping cough, rheumatism, stiff neck, and nasal catarrh; "Harosma," capsules, each containing 2.5 grains phenacetin, 2.7 grains aspirin, and one-seventh grain caffeine, represented as containing 4 grains phenacetin, for the paroxysms of hay fever and asthma, for rose fever, sinus, rhinitis, grippe, running nose, and weeping eyes.

"Mentos," a perfumed water solution of sulphur, borax, ammonia, and sodium bicarbonate, for dandruff, falling hair, ringworm, scalp irritations, psoriasis, and eczema; "Miller's Antiseptic Oil," kerosene with small amounts of capsicum and volatile oils including turpentine, wintergreen, and sassafras, represented as "snake oil," for aches and pains, muscular rheumatism, lumbago, corns, burns, scalds, diarrhea, cramps, sore throat, influenza, colds, pneumonia, and croup.

"Naco Nature's Aid," iron sulphate in water, with small amounts of aluminum, calcium, magnesium, manganese, sodium, potassium, and phosphorus compounds, falsely represented as antiseptic, for sores, burns, cuts, indigestion, rheumatism, pus in the kidneys, irritated bladder, dysentery, ptomain poisoning, acute diarrhea, sore throat, ulcerated tonsils, toothache, erysipelas, and carbuncles.

"Old Trusty Cough Mixture," a syrup containing creosote, plant extracts including wild cherry, and aromatics including menthol, for bronchial and pulmonary troubles in pets; "Old Trusty Ear Canker Drops," consisting of an oil (found to be rancid), an emulsifier and small amounts of calcium sulphate crystals, for cankers, abscesses and other ear sores in pets; "Old Trusty Tonic," a glycerin and water solution of iron compounds, strychnin, creosote, and oil of anise, for distemper; "Old Trusty Vermifuge Jr.," castor oil with small amounts of tetrachlorethylene and oil of anise, for worms in young dogs; "Old Trusty Vi-Ti," yeast and salt, for distemper, harsh coat, scurvy, vitamin deficiencies, and chorea in dogs.

"Rawleigh's All-Medicine Hog Mixture," sodium chlorid, phosphate, thiosulphate and bicarbonate, ferrous sulphate, sulphur, charcoal, and a plant laxative, offered as a tonic for hogs, for fattening, to stimulate the liver and the appetite, overcome indigestion, gastric ulcers, catarrh of the stomach, fermentative dyspepsia, and necrotic enteritis; "Rawleigh's Nasal Relief," a petrolatum-base ointment, containing menthol, camphor, and chlorbutanol (the chlorbutanol was not declared on the label as a chloroform derivative), for nasal catarrh, hay fever, chronic sore throat, and catarrhal deafness.

"Silver Crown Hair-Scalp Tonic," water with one per cent alcohol, quinin, glycerin, and small amounts of iron, sodium and sulphur compounds, perfume, and coloring matter, for dandruff, itching scalp, falling hair, eczema, and other scalp conditions.

"Sitroux Aids," tissue-paper handkerchiefs with menthol, cedar oil, and oil of eucalyptus, for sinus, hay fever, rose fever, and other nasal irritations; "Sphinx Herb

(Continued on Page 41)



When Steers Had Long Horns

THE medicinal value of the glands of internal secretion was not recognized.

But times have changed, as well as cattle. Now, the therapeutic value of certain gland products is definitely established and each year adds to our knowledge in this important field of therapeutics.

To the physician prescribing gland products we urge specification of "Wilson," because it connotes a product made at the source of supply from fresh glands, processed promptly, with the aim of conserving maximum hormone activity, in a laboratory devoted exclusively to the endocrine field.



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LIGATURES and DIGESTIVE FERMENTS

IN CASES OF *Malnutrition*

the use of this

"PROTECTIVE FOOD DRINK"

is indicated



THE DIETETIC VALUES of Cocomalt establish it as a "protective food" in the opinion of many physicians.

For instance, Cocomalt is rich in Calcium and Phosphorus—but more than that Cocomalt also has a rich Vitamin D content which enables the system to utilize the Calcium and Phosphorus. Each glass of Cocomalt in milk provides .33 gram of Calcium, .26 gram of Phosphorus, 81 U.S.P. units of Vitamin D.

Furthermore, each ounce of Cocomalt, the amount used to prepare one cup or glass, contains 5 milligrams of Iron in readily-assimilated form. Thus, three glasses or cups of Cocomalt supply the average normal daily iron requirement.

These important and vital food essentials plus the protein and carbohydrate content signalize the value of Cocomalt for the diet of expectant mothers, undernourished children, elderly people, nursing mothers, convalescents. Cocomalt is easily digested, quickly assimilated.

Cocomalt is Palatable and Inexpensive

Two added virtues that make this "protective food drink" deservedly popular with physicians and patients alike. Of distinctive and appetizing taste, this protective food drink costs little in proportion to its merit. It may be served Hot or Cold as you prescribe.

Cocomalt is sold at drug and grocery stores in ½-lb. and 1-lb. purity sealed cans. Also, for professional use, in 5-lb. cans available at a special price.

*Cocomalt is the registered trade-mark of
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Please send me a trial size can of Cocomalt without charge.

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They Satisfy*



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Fly Your Patients!
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Fully approved by the American College of Surgeons and the American Medical Association for Resident and Intern Training.

Limited Facilities for Part-Pay Treatment

(Continued from Page 38)

Tea," consisting mostly of dried senna leaves and pods, with fennel seed, anise seed, elder flowers, buckthorn bark, dog grass, orange peel, ginger root and safflowers, for pimples, dizziness, toxemia, minor eruptions, bad breath, colitis, digestive disturbances, and fatigue.

"Vapor Balm," petrolatum with menthol and wintergreen, for local congestion, irritation and inflammation, rheumatism, neuralgia, chest colds, muscular soreness, bruises, headaches, skin irritation, and affections of the air passages; and "Vita-Mil," consisting of 23 per cent Epsom salt, and plant drugs including extract of cascara and anise oil, represented as "made from roots, herbs and bark from all parts of the earth, containing no harmful drugs."

Diagnosis of Silicosis.—Gardner thinks that, regardless of the history of exposure to dust, a diagnosis of silicosis should not be made until generalized discrete nodular shadows are visible in the lung fields. Large localized shadows suggest complicating infection, but there is a conglomerate type of simple silicosis that occurs in the absence of active infection. It may result from pulmonary damage by previous infection that has healed. It can be differentiated from active infection only by careful clinical study and by repeated roentgenograms to exclude change

For Acidity and Allied Conditions, we suggest ADAMS SPRINGS MINERAL WATER



●MANY physicians recommend the water in conjunction with the treatment of stomach, liver and kidney trouble.

ADAMS MINERAL SPRINGS is one of the seven known iron and manganese bi-carbonate springs in the world, and the only one in Western America.

It is not a cure-all, but it overcomes acid excesses in the body, and is a very mild but wonderfully effective eliminator. The bowels function without spasm, the kidney output is greatly increased, and there is marked drainage of bile from the gall bladder and liver.

There is also some constitutional upset for a few days, particularly in gall bladder cases. But this is soon over and your patient begins to show improvement and is now in condition to profit by any medication you may prescribe. If the case is an operative one, you have improved your patient and made of him a better risk.

We will be pleased to cooperate in any way whatever, and samples of water are yours for the asking.

A Natural Mineral Water

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By PROF. SYDNEY A. TIBBETTS, *Berkeley*

MANGANESE	1.3 parts per million
IRON	12.5 parts per million
CALCIUM	173.3 parts per million
MAGNESIA	339.3 parts per million
SODIUM	365.0 parts per million
SILICA	93.0 parts per million
CHLORINE	38.3 parts per million
SULPHATE	16.1 parts per million
NITRATE	0 parts per million
PHOSPHATE	.7 parts per million
CARBONATE	1551.4 parts per million
TOTAL	2591.4 parts per million

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Steam heated
 hotel, open all
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3000 feet up
 in the Lake
 County Pines.

(Since 1870)



in the character and size of the lesion. The silicotic lung may exhibit the usual manifestations of tuberculosis, superimposed on a background of generalized nodulation; more common are the massive foci of consolidation due to silico-

(Continued on Next Page)

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(Continued from Preceding Page)

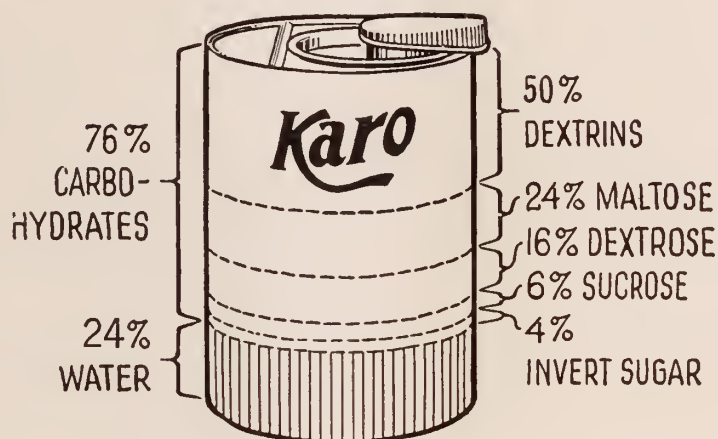
tuberculosis. These may be situated in the upper parts of the lung, where they result from reactivated apical foci of tuberculosis, but frequently they occur in the middle or lower part of the lung. They consist of a very chronic combination of tuberculosis and silicosis progressing simultaneously in the same area. They give rise to much less pronounced symptoms of intoxication than tuberculosis alone. More acute forms of tuberculosis, aspiration disease and military tuberculosis occur, but they are not very common. Nonsiliceous dusts are generally responsible for an exaggeration of the linear markings of the lung. As far as known, the slight parilymphatic reactions responsible for them do not interfere with pulmonary function and they do not alter the native susceptibility to tuberculosis. Asbestosis is not so well understood. The roentgenogram shows a diffuse haziness of the lower lung fields and later a very fine uniform stippling. Whether chronic pleurisy, increased linear markings and conglomerate shadows are due to the dust, to secondary changes incident to collapse of the lobules, or to complicating infection, has not been definitely settled. The appearance of a tuberculous lesion in the asbestosis lung is apparently not modified. There may be some tendency toward chronicity.—*Annals of Internal Medicine.*

Medical School at Oxford.—Lord Nuffield, automobile manufacturer, has made the munificent offer of \$6,250,000 to Oxford University for the establishment of a graduate medical school, which has been gratefully accepted. He has previously shown great interest in medical work by his benefactions to hospitals and otherwise. By discussion with the leaders of the medical profession he is well acquainted with the problems of practice and of research. He realizes that progress in medical science is reaching a stage at which it is desirable for those who work in the field of research to undergo a period of postgraduate training in modern methods of investigation, to keep in close touch with the sciences ancillary to medicine and to pur-

(Continued on Page 44)

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A. H. WARNER, Ph. D.

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sue their studies unhampered by the cares of private practice and routine teaching. Thence it is an easy step to the conception that a postgraduate medical school in a university town, in which all the scientific departments are within easy reach of the hospitals and in which the coordination of health services are established, would improve the facilities of those engaged in clinical work, whether institutional or that of general practice. In his presidential address at the recent meeting of the British Medical Association at Oxford, Sir Farquhar Buzzard spoke of the development of such a school at Oxford as an ambitious dream, thus filling the one conspicuous gap in the system of medical services. There is already at Oxford an Institute of Medical Research on a small scale, which Lord Nuffield founded. It is largely due to him that the Oxford hospitals have been reequipped and enlarged and are now provided with 650 beds. It is a condition of his offer that administration of the funds should provide for harmonious cooperation between the university and the hospitals.

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The work of the mason is to build, of the physician to heal, of the scholar to study. Through teaching he may share his knowledge with other inquiring minds. An age of fine culture is always one of effective study. In it scholars are unhampered in their search for truth. No tyrant forbids them to lift their eyes to the hills, nor prescribes what their findings shall be. Only through an unshackled spirit of inquiry can they find the truth that builds civilization and makes men free. George Eliot was not the one to observe the scholar's "power of persevering, devoted labor." The university, which Milton called the "house of scholarship," is a bulwark of the state and a mother to civilization. "What shall become of that commonwealth," says Hooker, "which hath not the eye of learning to beautify, guide, and direct?"

He who fears criticism is hopeless. Only those who do things are criticized. The idler is lost sight of in the march of events, but the doer is watched and criticized. . . . Take your part in life's stage and play your part to the end: Stand for what is good; be a doer, not a drone; look the world in the face and let the critics criticize.—Thomas Jefferson.



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I Annual Session Program

Del Monte, California, May 2-6, 1937

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II

Pre-Convention Bulletin

Reports of Officers and Committees

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SALUTATION FROM PRESIDENT PALLETTE

To the Members of the California Medical Association and their friends, your Officers and Committee Members extend a cordial greeting.

We are most fortunate this year that the Association is holding its sixty-sixth annual meeting in one of the most delightful places in all America. Monterey, this first capital city of California, with its surroundings, constitutes a spot unsurpassed in all the world for scenic beauty, historic interest, and facilities for hospitality.

Monterey is the very cradle of Californian history. Viscaino landed here in 1602 and took possession in the name of the King of Spain. In 1821, Monterey became the capital of the Mexican Province of California. The

first Constitution of the American State of California was framed here in the first capitol, Colton Hall, still standing, in September, 1849. Other historic buildings still to be seen here are the house of Governor Alvarado, the Presidio chapel, General Sherman's headquarters, the Larkin House, Robert Louis Stevenson's home, the first United States Customs House, and the first theater in California, where many noted actors appeared before and during the days of the gold-rush. Then there are the famous Seventeen-Mile Drive, Pebble Beach, Carmel, and Carmel Mission where Junipero Serra is buried. The numerous unexcelled golf courses in the neighborhood will appeal to many of our members. Hotel Del Monte, the meeting headquarters, has been well referred to as "the world's best-loved resort."

Several objectives are to be aimed at in a meeting of this kind. The opportunity of meeting colleagues and renewing old friendships is most valuable. Doctors who are acquainted are usually good friends. The solidarity of organized medicine is thus increased. Our health, both physical and mental, must be benefited by even a short period of relaxation from the responsibilities of practice. The consideration of the problems of medical economics and public relations is important.

After all, however, the presentation and discussion of the problems of the strictly scientific side of our profession is probably the most important. Much credit is due the Committee on Scientific Program, and to the writers of papers and their discussants for the preparation of the following program. The Section Officers have done their work well.

Those in charge have done their utmost with the hope that you will spend a most comfortable and enjoyable few days at Del Monte. The attendance should be large.

May all Association members, including those of the Auxiliary and their friends in attendance, have a most profitable and a most enjoyable time!



EDWARD M. PALLETTE, M. D.
President, California Medical Association
1937

Cordially yours,

EDWARD M. PALLETTE.

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Howard Morrow, President-Elect.

Frederick C. Warnshuis, Secretary-Treasurer.

Communications for the Public Relations Department should be addressed to the Director, Frederick C. Warnshuis, M. D., Room 2004, Sutter Street, San Francisco.

Cancer Commission

Charles A. Dukes (Chairman), Oakland.....	1937
Lyell C. Kinney (Vice-Chairman), San Diego.....	1937
Alson R. Kilgore (Secretary), San Francisco.....	1937
Orville Meland (Secretary for Southern Section), Los Angeles.....	1938
A. Herman Zeiler, Los Angeles.....	1938
Gertrude Moore, Oakland.....	1938
Harold Brunn, San Francisco.....	1939
Henry J. Ullmann, Santa Barbara.....	1939
Clarence G. Toland, Los Angeles.....	1939

Communications for the Cancer Commission should be addressed to the secretary, A. R. Kilgore, M. D., Room 2004, 450 Sutter Street, San Francisco.

SPECIAL COMMITTEES**Local Committee on Arrangements—Del Monte Session**

J. A. Merrill (Chairman).....	Monterey
Mast Wolfsohn.....	Monterey
Paul M. Hunter.....	Pebble Beach
H. Spencer Hoyt.....	Pacific Grove
E. F. Kehr.....	Carmel

Committee on Maternal Welfare

T. Henshaw Kelly (Chairman).....	San Francisco
Lyle G. McNeile.....	Los Angeles
Ralph J. Thompson.....	Los Angeles
T. Floyd Bell.....	Oakland
Hans F. Schluter.....	Sacramento

Committee on Hospital Insurance Plans

T. Henshaw Kelly (Chairman).....	San Francisco
William H. Kiger.....	Los Angeles
Charles A. Dukes.....	Oakland
F. F. Gundrum.....	Sacramento

**Committee on a Qualifying Certificate (Basic Science)
Law**

George H. Kress (General Chairman).....	Los Angeles
Morton R. Gibbons (Chairman for Bay Re- gion).....	San Francisco
Edward M. Palette (Chairman for Southern California).....	Los Angeles
Junius B. Harris (Chairman for Remainder of State).....	Sacramento

Committee on Syphilis

Howard Morrow (Chairman).....	San Francisco
Charles W. Barnett.....	San Francisco
William H. Goeckerman.....	Los Angeles

REGISTRATION INFORMATION

Registration and Information. The registration and information desk is located in the lobby, Del Monte Hotel. All persons attending the convention, whether members or not, are requested to register immediately on arrival. Beginning Monday, May 3, registration secretaries will be on duty daily from 9 a. m. until 5 p. m.

Programs and "Pre-Convention Bulletin." The registration clerks will give to every member a copy of the program. The "Pre-Convention Bulletin" will be printed in the April issue of CALIFORNIA AND WESTERN MEDICINE. Delegates and alternates are especially requested to read the reports of officers and committees.

Guests and Visitors. All guests and visitors are requested to register. All general meetings and scientific meetings are open to visitors and guests.

Badges. Four kinds of badges will be issued by the registration bureau:

1. **Members.** Only active, associate, retired or honorary members of the California Medical Association will be issued the usual membership badge.

2. **Guests.** A guest badge will be issued to all fraternal delegates and visiting physicians who are attending the 1937 session.

3. **Delegates and Alternates.** The usual official badge for each delegate and alternate is provided for this purpose, and will be issued only to one authorized to wear it.

4. **Officers.** An official badge is provided for all officers and members of the Council.

Suggestions and Constructive Criticism. The officers and committees have tried to do everything possible to make the session a success. Suggestions and constructive

criticism calculated to make future sessions more useful will be welcomed by any of the officers. Complaints of whatever character should be promptly made at the registration desk, where they will receive attention.

Announcements

Please register on arrival and secure program and special announcements. Registration Bureau, Del Monte Hotel.

Delegates will please file *credentials* with committee at 7:00 p. m., Monday, May 3.

Consult Bulletin Board daily for schedule of *Scientific Exhibit Demonstrations*.

Consult tabulated diagram for *meeting places of Scientific Sections*.

President's Dinner Tickets: Guests of Hotel Del Monte will obtain their tickets for the President's Dinner from Hotel Clerk's desk—others, not registered at the Hotel Del Monte, will secure President's Dinner tickets at the Registration Desk. Price, \$2.50 per person for persons not guests of Hotel Del Monte.

Golf Green Fees—\$1.50. Please register for tournament—Fee \$2.00.

Riding Horses—\$2.00 per ride (additional charge of \$2.00 for services of groom).

Swimming Pool—50 cents per person. (No charge to hotel guests.)

Woman's Auxiliary members register at Hotel Del Monte, main lobby.

Consult program for *entertainment events*.
Visit *commercial exhibits*.

MEMBERS OF HOUSE OF DELEGATES—34th ANNUAL SESSION

DELEGATES EX OFFICIO (21)

Edward M. Pallette, Los Angeles.....President
 Howard Morrow, San Francisco.....President-Elect
 William W. Roblee, Riverside.....
Speaker of the House of Delegates
 John H. Graves, San Francisco.....
Vice-Speaker of House of Delegates
 Frederick C. Warnshuis, San Francisco.....
Secretary-Treasurer
 George H. Kress, Los Angeles.....Editor
 C. L. Emmons, Riverside (1938).....Councilor 1st District
 Carl R. Howson, Los Angeles (1939).....Councilor 2nd District
 Henry J. Ullmann, Santa Barbara (1937).....
Councilor 3rd District
 Axel E. Anderson, Fresno (1938).....Councilor 4th District
 Alfred L. Phillips, Santa Cruz (1939).....Councilor 5th District
 Karl L. Schaupp, San Francisco (1937).....
Councilor 6th District
 Oliver D. Hamlin, Oakland (1938).....Councilor 7th District
 C. E. Schoff, Sacramento (1939).....Councilor 8th District
 Henry S. Rogers, Petaluma (1937).....Councilor 9th District
 Harry H. Wilson, Los Angeles (1938).....Councilor-at-Large
 C. O. Tanner, San Diego (1939).....Councilor-at-Large
 William H. Kiger, Los Angeles (1937).....Councilor-at-Large
 Morton R. Gibbons, San Francisco (1938).....
Councilor-at-Large
 T. Henshaw Kelly, San Francisco (1939).....
Councilor-at-Large
 Junius B. Harris, Sacramento (1937).....Councilor-at-Large

ELECTED DELEGATES (128)

Delegates

Alternates

Alameda County (10)
 A. A. Alexander
 Leonard Barnard
 John Dougherty
 Edward N. Ewer
 T. C. Lawson
 H. Gordon MacLean
 Frank Makinson
 Roy Nelson
 George Reindle
 Hobart Rogers
Butte County (1)
 Joseph O. Chiappella
Contra Costa County (1)
 L. H. Fraser
Fresno County (3)
 H. A. Randel
 G. W. Walker
 E. R. Scarboro
Humboldt County (1)
 Guido F. Norman
Imperial County (1)
 L. C. House
Kern County (1)
 Louis A. Packard
Kings County (1)
 William F. Chamlee
Lassen-Plumas-Modoc Counties (1)
 G. S. Marin
Los Angeles County (42)
 E. Vincent Askey
 Harold Dewey Barnard
 John V. Barrow
 Karl M. Bonoff
 H. L. Charles
 Fred B. Clarke
 Walter R. Crane
 John W. Crossan
 William H. Daniel
 George Dock
 Wallace Dodge
 Alvin G. Foord
 Orrie E. Ghrist
 Lowell S. Goin
 Walter L. Huggins
 E. Eric Larson
 William H. Leake
 Percy T. Magan
 George D. Maner
 William R. Molony
 E. Earl Moody
 Thomas C. Myers
 John W. Nevius
 John P. Nuttall
 James P. Percy
 Charles E. Phillips
 Sterling N. Pierce
 F. M. Pottenger, Sr.
 F. M. Pottenger, Jr.
 Robert E. Ramsay
 Oscar Reiss
 E. T. Remmen
 John C. Ruddock
 Harlan Shoemaker
 Philip J. Stephens
 Charles T. Sturgeon
 F. C. Swearingen
 R. G. Taylor
 C. G. Toland
 Walter F. Wessels
 Howard F. West
 A. H. Zeller
Alameda County (10)
 V. G. Alderson
 T. F. Bell
 John Ewer
 C. B. Fowler
 Jefferson Larkey
 George Nesche
 Robert S. Peers
 Leland H. Taylor
 H. J. Templeton
 D. D. Toffelmier
Butte County (1)
 N. T. Enloe
Contra Costa County (1)
 S. N. Weil
Fresno County (3)
 Neil Dau
 R. W. Dahlgren
 K. D. Luechauer
Humboldt County (1)
 Joseph S. Woolford
Imperial County (1)
 Philip Hodgkin
Kern County (1)
 F. J. Grundy
Kings County (1)
 P. K. Edmunds
Lassen-Plumas-Modoc Counties (1)
 Fred J. Davis, Sr.
Los Angeles County (42)
 Elliot Alden
 L. A. Alesen
 F. X. Ammann
 C. Maxwell Anderson
 V. L. Andrews
 A. Elmer Belt
 F. H. Brandt
 Harry V. Brown
 Martin G. Carter
 Cyril B. Courville
 Charles H. Cowgill
 Egerton L. Crispin
 R. L. Cunningham
 Wirt B. Dakin
 Kenneth S. Davis
 Edward B. Dewey
 Edward T. Dillon
 John B. Doyle
 Ralph B. Eusden
 William V. C. Francis
 David M. Ghrist
 Albert L. Hill
 A. B. Hromadka
 Isaac H. Jones
 W. J. Lakey
 Francis M. McKeever
 Lyle G. McNeille
 Orville N. Meland
 Carl L. Mulfinger
 William H. Olds
 H. A. Putnam
 R. O. Raulston
 H. E. Schifflbauer
 V. DeMott Sedgwick
 John W. Shuman
 Willard J. Stone
 Packard Thurber
 Donald G. Tollefson
 Robert A. Walker
 Burnett W. Wright
 Charles S. Young
 Nelson A. Young

Delegates

Alternates

Marin County (1)
 Carl W. Clark
 J. O. Hawkins
Mendocino-Lake Counties (1)
 Ruggles A. Cushman
 C. A. Craig
Merced County (1)
 E. A. Jackson
 W. E. Liley
Monterey County (2)
 Mast Wolfsohn
 James H. McPharlin
 Paul M. Hunter
 Walter H. Farr
Napa County (1)
 George I. Dawson
 Dwight H. Murray
Orange County (3)
 G. Wendell Olson
 Dexter Ball
 Harry Huffman
 Milo Tedstrom
 Harold F. Gobar
 Merrill W. Hollingsworth
Placer County (1)
 Lucas W. Empey
 Mildred E. Thoren
Riverside County (2)
 A. L. Bramkamp
 Bon O. Adams
 R. B. McCarty
 L. J. Clark
Sacramento County (3)
 Frank A. MacDonald
 Nathan G. Hale
 Frederick N. Scatena
 Orrin S. Cook
 Paul W. Christman
 Wayne E. Pollock
San Benito County (1)
 Robert S. Geen
 John Harruf
San Bernardino County (3)
 Walter Pritchard
 H. M. Walton
 H. G. Gentry
 Carl M. Hadley
 Philip W. Lawler
 A. L. Weber
San Diego County (6)
 W. H. Barrow
 E. G. Crabtree
 S. J. McClendon
 J. F. Churchill
 W. C. Crabtree
 W. H. Newman
 W. H. Geistweit, Jr.
 R. C. Lounsberry
 W. M. Alberty
 B. F. Eager
 Ralph Kaysen
 F. E. Toomey
San Francisco County (17)
 Rea E. Ashley
 Dorothy W. Atkinson
 Elbridge J. Best
 Zera E. Bolin
 Edwin L. Bruck
 Loran R. Chandler
 G. D. Delprat
 J. C. Geiger
 Thomas E. Gibson
 Phillip K. Gilman
 George N. Hosford
 Irving S. Ingber
 Alson R. Kilgore
 Stanley H. Mentzer
 Ronald P. Seitz
 Robert S. Stone
 Wilber F. Swett
 George H. Becker
 H. Glenn Bell
 A. Lincoln Brown
 Howard A. Brown
 Donald A. Carson
 John W. Cline
 Rudolph L. Dresel
 Leo Henry Garland
 Ernst Gehrels
 Nelson J. Howard
 Thomas J. Lennon
 Frederick L. Reichert
 John J. Sampson
 Emery M. Seeburt
 Huldah E. Thelander
 David A. Wood
 Rodney A. Yoell
San Joaquin County (2)
 Dewey R. Powell
 George H. Sanderson
 C. A. Broadus
 Percy B. Gallegos
San Luis Obispo County (1)
 James M. Marshall
 A. H. Wilmar
San Mateo County (2)
 Hartzell H. Ray
 J. Garwood Bridgman
 William F. Knorp
 N. D. Morrison
Santa Barbara County (3)
 Rodney Atsatt
 Hugh Freidell
 Richard Evans
 Harry E. Henderson
 P. A. Gray
 William H. Eaton
Santa Clara County (4)
 C. M. Burchfiel
 C. Kelly Canelo
 R. Stanley Kneeshaw
 Russel V. Lee
 George L. Barry
 Merlin T.-R. Maynard
 Earl O. G. Schmitt
 John Hunt Shephard
Santa Cruz County (1)
 F. E. Blaisdell, Jr.
 J. F. Harrington
Shasta County (1)
 Henry L. White
 Leslie J. Seeley
Siskiyou County (1)
 C. C. Dickinson
 V. W. Hart
Solano County (1)
 John W. Green
 Arvil E. Chappell
Sonoma County (2)
 Leonard W. Hines
 Carol B. Andrews
 F. O. Butler
 Mark Lewis
Stanislaus County (1)
 R. Stewart JIatt
 E. F. Hagedorn
Tehama County (1)
 R. G. Frey
 F. J. Bailey
Tulare County (1)
 J. C. McClure
 W. P. Parkinson
Ventura County (1)
 G. C. Coffey
 A. A. Morrison
Yolo-Colusa-Glen Counties (1)
 Charles A. Poage
 Tom H. Brown
Yuba-Sutter Counties (1)
 F. P. Wisner
 Stanley R. Parkinson

PROGRAM: BY DAYS**Sunday, May 2**

- 9:00 a.m. to 4:30 p.m.—Clinical-Pathological Conference (under auspices of the Cancer Commission).
 10:00 a.m. to 4:00 p.m.—Radiological Conference (under auspices of the Cancer Commission).
 12:00 noon to 5:00 p.m.—Scientific and commercial exhibits.
 12:00 noon—North and South Golf Tournament.
 7:30 p.m.—Council meeting.

Monday, May 3

- 10:00 a.m.—Opening General Meeting.
 1:30 p.m.—Section meetings.
 8:15 p.m.—House of Delegates.

Tuesday, May 4

- 7:45 a.m.—Past Presidents' breakfast.
 8:30 a.m.—Section meetings.
 11:15 a.m.—General Meeting (Clinical-Pathological Conference).

- 1:00 to 6:00 p.m.—Recreation. (Golf, skeet-shoot, seventeen-mile drive.)
 7:30 p.m.—President's dinner, reception, and dance.

Wednesday, May 5

- 8:30 a.m.—Section meetings.
 11:15 a.m.—General Meeting (Social Security, legislation, and economics).
 1:30 p.m.—Section meetings.
 4:15 p.m.—Meeting of Medical Society of the State of California.
 8:15 p.m.—House of Delegates.

Thursday, May 6

- 8:30 a.m.—Section meetings.

✓ ✓ ✓

Note.—Council meets daily during the annual session.
 Watch bulletin board for hours during which demonstrations will be given in the Scientific Exhibits Section.
 Utilize every opportunity to visit the commercial exhibits.

COMMERCIAL EXHIBITS

(For description of commercial exhibits, see page 34)

- Aloe Company, A. S., 932 South Hill Street, Los Angeles. Booths Nos. 19 and 20.
 Ayerst, McKenna & Harrison, Ltd., 781 Williams Street, Montreal, Canada. Booth No. 2.
 Baxter, Don, Inc., 1505 Gardena Avenue, Glendale. Booth No. 5.
 Bilhuber-Knoll Corporation, 154 Ogden Avenue, Jersey City, New Jersey. Booth No. 9.
 Borden Company, The, 350 Madison Avenue, New York City, New York. Booth No. 31.
 Calso Company, The, 524 Gough Street, San Francisco. Booth No. 25.
 Coca-Cola Company, The, Atlanta, Georgia. Booth No. 14.
 Cutter Laboratories, Berkeley. Booth No. 13.
 DeVilbiss Company, The, Toledo, Ohio. Booth No. 22.
 Dictograph Products Company, Inc., 457 Powell Street, San Francisco. Booth No. 15.
 Fischer & Company, H. G., 450 Sutter Street, San Francisco. Booth No. 37.
 General Electric X-Ray Corporation, 2012 Jackson Boulevard, Chicago, Illinois. Booth No. 17.
 Gerber Products Company, Fremont, Michigan. Booth No. 1.
 Golden State Company, Inc., 425 Battery Street, San Francisco. Booths Nos. 27 and 28.
 Heinz Corporation, H. J., 2998 San Pablo Avenue, Berkeley. Booth No. 30.
 Kellogg Sales Company, 155 Montgomery Street, San Francisco. Booth No. 26.
 Lederle Laboratories, 450 Sutter Street, San Francisco. Booth No. 11.
 Libby, McNeill & Libby, Chicago. Booth No. 3.
 Liebel-Flarsheim Company, 303 West Third Street, Cincinnati, Ohio. Booth No. 32.
 Mead Johnson & Company of California, 670 Third Street, San Francisco. Booth No. 12.
 Medical Protective Company, The, Wheaton, Illinois. Booth No. 21.
 Mennen Company, The, 345 Central Avenue, Newark, New Jersey. Booth No. 36A.
 Merck & Company, Inc., Rahway, New Jersey. Booth No. 6.
 Midwest Instrument Company, 1870 Ogden Avenue, Chicago, Illinois. Booth No. 29.
 Pet Milk Sales Corporation, St. Louis, Missouri. Booth No. 16.
 Petrolagar Laboratories, 8134 McCormick Boulevard, Chicago. Booth No. 10.
 Philip Morris & Company, Ltd., 119 Fifth Avenue, New York. Booth No. 7.
 S. M. A. Corporation, Cleveland, Ohio. Booth No. 8.
 Stacey, J. W., Inc., Flood Building, San Francisco. Booth No. 18.
 Stokely Brothers & Company, Inc., South East Street, Indianapolis. Booth No. 4.
 Travers and Hennig, Inc., 429 Sutter Street, San Francisco. Booth No. 36B.
 Vitamin Products Company, 2023 West Wisconsin Avenue, Milwaukee. Booth No. 23.
 Western Surgical Supply Company, Ltd., 1926 Wilshire Boulevard, Los Angeles. Booths Nos. 33 and 34.
 Zweegman School for Medical Secretaries, 450 Sutter Street, San Francisco. Booth No. 24.

I—GENERAL MEETINGS

All General Meetings Will Be Held in the Auditorium, Hotel Del Monte

First General Meeting

Monday, May 3, 10 a. m.

1. *Address of Welcome*—Garth Parker, M. D., President, Monterey County Medical Society.
2. *President's Address*—Edward M. Pallette, M. D., Los Angeles.
3. *A Summary of Changes in the White Blood Cells in Various Diseases*—Jesse G. M. Bullova, M. D., New York University College of Medicine, New York.

Consideration will be given to our present-day conception of the origin, the function of the different types of white blood cells and the changes which occur in them in various diseased conditions. The discussion will include the response of the leukocytes to different infections and a consideration of the variance of these cells from the standpoint of diagnosis, prognosis, and treatment in the leukemias, infectious mononucleosis, and agranulocytic angina.

4. *The Uterine Cervix: Its Disorders and Their Management*—Norman F. Miller, M. D., University of Michigan Medical School, Ann Arbor, Michigan.

In evaluating common lesions of the cervix the careful examiner sees more than just a local disorder. He envisions future disease located in the cervix and forecast by the insignificant appearing disorder before him.

To make the most of this opportunity for prevention of disease of the female pelvis, a clear understanding of the cervix and its diseases are essential.

This paper represents a careful and practical scrutiny of the subject.

Second General Meeting

Tuesday, May 4, 11:15 a. m.

1. *Clinical-Pathological Conference*—Conducted by Cyrus C. Sturgis, M. D., Professor of Internal Medicine, University of Michigan, Ann Arbor, Michigan.

This conference will present selected cases with comments by the Conductor. After the presentation of case histories and laboratory findings, an opportunity will be given to ask questions pertinent to the subject. The Conductor will then summarize the case, after which the protocol will be read.

The following cases will be presented:

Case 1—Heart disease.

Case 2—Blood, liver, spleen complex.

Case 3—Anomaly of the pancreas.

Copies of clinical histories will be given to all attending this Clinical-Pathological Conference.

Third General Meeting

Wednesday, May 5, 11:15 a. m.

1. *State Legislation*—Junius B. Harris, M. D., Sacramento.
2. *Hospital and/or Medical Care Under Insurance*—T. Henshaw Kelly, M. D., San Francisco.
3. *Alameda County Hospitalization Insurance Plan*—Daniel Crosby, M. D., Oakland.
4. *Federal Legislation and Summarization*—William C. Woodward, M. D., LL. D., Director of the Bureau of Legal Medicine and Legislation of the American Medical Association, Chicago.

This general meeting was arranged at the request of many members who desire authentic information upon social movements involving medical care.

II—HOUSE OF DELEGATES MEETINGS

34th ANNUAL SESSION—HOTEL DEL MONTE

Speaker, W. W. ROBLEE, Riverside

Vice-Speaker, J. M. GRAVES, San Francisco

Secretary, F. C. WARNSHUIS, San Francisco

FIRST MEETING

Monday, May 3, 8:00 p. m.

Auditorium

Order of Business

1. Call to order.
2. Report of the Reference Committee on Credentials.
3. Roll call.
4. Announcement and approval of the following Reference Committees:
 - (a) Reports of Officers, Standing and Special Committees.
 - (b) Resolutions, New and Miscellaneous Business.
 - (c) Credentials.
5. Address of the President, Edward M. Pallette.
6. Conferring certificates on living Past Presidents—W. W. Roblee, Speaker.
- Reports*:*
 7. Report of the Council, Morton R. Gibbons, Chairman.
 8. Report of the Trustees of the California Medical Association, Morton R. Gibbons, President.
 9. Report of the Auditing Committee, Karl L. Schaupp, Chairman.
 10. Report of the Secretary-Treasurer, F. C. Warnshuis.
 11. Report of the Editor, George H. Kress.
 12. Report of the General Counsel, Hartley F. Peart.
 13. Report of the Committee on Public Relations, Charles A. Dukes, Chairman.

14. Report of Standing and Special Committees:

A. Standing Committees*

Executive Committee—Karl L. Schaupp.
 Committee on Associated Societies and Technical Groups—William J. Kerr.
 Committee on Health and Public Instruction—Fred B. Clarke.
 Committee on History and Obituaries—Frank R. Makinson.
 Committee on Hospitals, Dispensaries and Clinics—Daniel Crosby.
 Committee on Industrial Practice—Morton R. Gibbons.
 Committee on Medical Defense—George G. Reinle.
 Committee on Medical Economics—John H. Graves.
 Committee on Medical Education and Medical Institutions—Loren R. Chandler.
 Committee on Membership and Organization—E. Vincent Askey.
 Committee on Postgraduate Activities—C. G. Toland.
 Committee on Publications—Percy T. Magan.
 Committee on Public Policy and Legislation—Junius B. Harris.
 Committee on Scientific Work—Frederick C. Warnshuis.
 Committee on Public Relations—Frederick C. Warnshuis.
 Cancer Commission—Charles A. Dukes.

* Reports of Officers, Standing and Special Committees are given in the "Pre-Convention Bulletin," printed as an Appendix to the Annual Session Program. (See page 37.)

* Reports of Standing and Special Committees listed below are printed in the Pre-Convention Bulletin, which immediately follows the annual session program. (See page 46.)

B. Special Committees:

- Special Committee on Arrangements—J. A. Merrill.
 Special Committee on Maternal Welfare—T. Henshaw Kelly.
 Special Committee on Hospital Insurance Plans—T. Henshaw Kelly.
 Special Committee on Qualifying Certificate—George H. Kress.
 Special Committee on Venereal Diseases—Howard Morrow.
 Committee of Five—William R. Molony, Sr.

15. Unfinished business.

1. Amendments to constitution:

A.—*Resolved*, That Section 1 of Article VII of the Constitution of this Association be and is hereby amended by inserting in the first paragraph thereof after the words "the President," the following:

"The Past President"; and, be it further *Resolved*, That Section 8 of Article VII of the Constitution of this Association be and is hereby amended by inserting in the first paragraph thereof after the words "the President," the following:

"The Past President"; and be it further *Resolved*, That Section 1 of Article X of the Constitution of this Association be and is hereby amended by inserting after the words "a president" the following:

"A Past president"; and, be it further *Resolved*, That Section 2 of said Article X of the Constitution of this Association and the title thereto be amended to read as follows: "Section 2—President-Elect, when and how elected; term of office. Past President."

"The House of Delegates at the regular annual session thereof shall elect the president-elect to serve until the adjournment of the final meeting of the House of Delegates at its next regular annual session. At the conclusion of the final meeting of the House of Delegates at its next regular annual session, such president-elect shall assume the office of president, and serve as such for the term of one year thereafter, or until his successor assumes office."

"At the expiration of his term of office the president shall become the past president and serve as such for a term of one year thereafter, or until his successor assumes office"; and be it further

Resolved, That Section 4 of Article X of the Constitution of this Association be and is hereby amended by inserting in the first paragraph thereof after the word "president" the following:

"Past president."

B.—*Resolved*, That Section 1 of Article XI of the Constitution of this Association be and is hereby amended as follows:

By striking out all of the fourth paragraph of said Section 1 of Article XI, reading as follows:

"All resolutions providing for appropriations shall be referred to the Council, and all appropriations approved by the Council shall be included in the annual budget."

And by inserting in lieu thereof the following:

"Any resolution passed and adopted by the House of Delegates at any regular or special session thereof, which provides for or contemplates the appropriation or expenditure of more than the sum of \$1,000, shall not be effective for any purpose unless and until approved by the Council. All appropriations, regardless of amount, approved and made by the Council shall, if expended, be reported to the House of Delegates at its next annual session, and any unexpended portion of any thereof shall be included in the annual budget."

16. Resolutions and new business.

(NOTE: All resolutions must be presented in writing and in triplicate.)

17. Approval of minutes.

18. In Memoriam—Deceased Members—Frederick C. Warnshuis.

19. Recess to Wednesday, 7:30 p. m.

SECOND MEETING

Wednesday, May 5, 8:00 p. m.

Auditorium

Order of Business

1. Call to order.
2. Supplemental report of Credentials Committee.
3. Roll call.
4. Announcement of place for 1938 annual meeting.
5. Elections:
 - (a) President-Elect.
 - (b) Speaker.
 - (c) Vice-Speaker.
 - (d) Councilors:
 - Third District—Henry J. Ullman, term expiring.
 - Sixth District—Karl L. Schaupp, term expiring.
 - Ninth District—Henry S. Rogers, term expiring.
 - (e) Councilors-at-Large:
 - William H. Kiger, term expiring.
 - Junius B. Harris, term expiring.
 - (f) Delegates to the American Medical Association—Incumbents:
 - Elbridge Best, San Francisco.
 - Lyell C. Kinney, San Diego.
 - Fred B. Clarke, Long Beach.
 - (g) Alternate Delegates to American Medical Association—Incumbents:
 - Robert S. Stone, San Francisco.
 - Harry H. Wilson, Los Angeles.
 - A. J. Scott, Los Angeles.
6. Announcement and approval of members of Standing Committees elected by the Council.
7. Report of Reference Committee:
 - (a) Reports of Officers, Standing and Special Committees.
 - (b) Resolutions, New and Miscellaneous Business.
8. Unfinished business.
9. Presentation of the President.
10. Presentation of President-Elect.
11. Presentation of Speaker and Vice-Speaker.
12. Approval of minutes.
13. Adjournment.

III—OTHER MEETINGS

CANCER COMMISSION PATHOLOGY
CONFERENCE

Sunday, May 2, 9 a. m. to 4:30 p. m.

Hotel Del Monte, Del Monte

The annual Conference on Pathology, held under the sponsorship of the Cancer Commission of the California Medical Association, will take place at Del Monte on May 2, 1937.

The program will include a full morning and afternoon session. The plan at present is to present short symposia upon various groups of tumors, with interesting cases interspersed through the meeting. It is hoped that reports on tumors exhibited at former sessions will be made.

All those desiring to present cases and slides are requested to return the same to the chairman of the committee, Dr. Z. E. Bolin, 490 Post Street, San Francisco, at their earliest convenience, accompanied by one hundred slides and a case history which is to be mimeographed. Those who wish to participate in the conference are requested to register with the chairman of the committee as soon as possible.

CANCER COMMISSION RADIOLOGY
CONFERENCE

Sunday, May 2, 10 a. m. to 4 p. m.

Hotel Del Monte, Del Monte

The Cancer Commission is again sponsoring a Radiological Conference on Sunday, May 2, at Del Monte. The meetings will be held in one of the rooms of the Hotel Del Monte, between 10 and 12 in the morning and 2 and 4 in the afternoon. In previous years a large number of doctors have drifted into these meetings without registering. This year only those who register, up to the number of thirty, will be admitted. This is because any greater number than this makes the meetings less profitable for everyone concerned. Please send your registration at once to the offices of the California Medical Association if you intend to be present. Do not register and hold someone else from a position if you do not intend to come. These meetings have always been the high-spot of the radiologists of the convention. We believe they will be better this year than ever.

Table I—Time and Places of Various Meetings and Entertainment

Meeting Place	Monday, May 3		Tuesday, May 4		Wednesday, May 5		Thursday, May 6	
	A. M.	P. M.	A. M.	P. M.	A. M.	P. M.	A. M.	P. M.
Auditorium	General Meeting	Surgery	Surgery General Meeting	— ENTERTAINMENT — GOLF — SKI — SHOOT	Surgery General Meeting	Symposium Medicine Surgery Obstetrics and Gynecology Pediatrics Pathology Eye, Ear, Nose and Throat Radiology	Surgery	
Grill Room		Medicine	Medicine		Medicine		Medicine	
Copper Cup		Obstetrics and Gynecology	Eye, Ear, Nose and Throat		Obstetrics and Gynecology	Anesthesi- ology		
Tower Room		Pediatrics	Urology		Radiology	Urology		
Art Gallery		Radiology	Industrial Medicine and Surgery		Eye, Ear, Nose and Throat		Eye, Ear, Nose and Throat	
Play Room		Neuropsy- chiatry	Neuropsy- chiatry					
Billiard Room		Pathology	Pathology		Industrial Medicine and Surgery			
Directors' Room	Council* Meeting	Dermatol- ogy	Dermatology		Pediatrics			
Private Dining Room			Past President's Breakfast 7:45 A. M.		Anesthesi- ology			
Main Dining Room								
				Presi- dent's Dinner 7:30				

* The Council meets each day during the annual session.

IV—SCIENTIFIC EXHIBITS

West Sun Terrace and Corridors

1. *Malignant Lesions of the Large Bowel*—Franklin I. Harris, M. D., Mount Zion Hospital, San Francisco; Joseph Levitin, M. D., Mount Zion Hospital, San Francisco; and Gerson Biskind, M. D., Mount Zion Hospital, San Francisco.

A series of preoperative x-rays, demonstrating malignant lesions of the large bowel (ascending colon, transverse and descending colon), with photographs of the particular specimens removed at subsequent operations.

The photographs include the gross pathology and microphotographs to illustrate the cellular structures of these malignant tumors, and postoperative follow-up x-rays of the large bowel in these patients, to illustrate complete restoration of function.

This series of exhibits shows the relatively good prognosis for restoration of health and function, and the type of intestinal resections in these cases which have given us a relatively low mortality.

The exhibits show the close relationship necessary for success that must exist between the radiologist, the surgeon, and the pathologist.

2. *New and Simplified Physical Method for Blood Detection*—Frederick Proescher, M. D., San Jose; Jesse Carr, M. D., St. Francis Hospital, San Francisco; and A. M. Moody, M. D., University of California, San Francisco.

The exhibit shows the effects of various degrees of heat upon the physical characteristics of blood.

3. *Pneumococcus Pneumonia*—W. P. Shepard, M. D., Metropolitan Life Insurance Company, San Francisco.

The importance of the pneumococcus pneumonia problem is illustrated in graphic charts showing pneumonia the third cause of death for the country as a whole, and more prevalent in certain so-called "pneumonia belts." Incidence of various types is illustrated, and a graphic description of the Neufeld rapid typing method is shown. Mortality savings from the prompt use of specific antisera, when available, is presented, and an estimate is given of the number of lives which might be saved if rapid typing and prompt administration of the antisera in suitable cases were universal.

4. *Two New Surgical Approaches to the Sympathetic Nervous System*—Felix L. Pearl, M. D., 450 Sutter Street, San Francisco.

The exhibit consists of diagrams and halftone drawings with descriptive legends depicting two new surgical approaches to the sympathetic nervous system. The first shows completely muscle-splitting extraperitoneal lumbar ganglionectomy and trunk resection. The second shows sacral ganglionectomy and trunk resection in conjunction with presacral neurectomy.

5. *Believe-It-or-Nots in Urology*—Wirt B. Dakin, M. D., 523 West Sixth Street, Los Angeles.

This exhibit shows cases of strange pathologic conditions and anomalies; unique findings and results in surgery; rare etiologic and curative factors.

6. *A Method of Visualizing Pyelograms in the Three Dimensions*—Nathan G. Hale, M. D., 1127 Eleventh Street, Sacramento; Ralph S. Graham, M. D.,

Table II—Schematic Plan of Section Meetings

Date	Section	Place of Meeting	Papers Presented
Monday May 3 1:30 p. m.	General Medicine General Surgery Obstetrics and Gynecology Dermatology and Syphilology Neuropsychiatry Pathology and Bacteriology	Grill Room Auditorium Copper Cup Room Directors' Room Play Room Billiard Room	1, 2, 3, 4, 5 21, 22, 23, 24, 25, 26 43, 44, 45, 46, 47 74, 75, 76, 77, 78, 79 94, 95, 96, 97 101, 102, 103, 104, 105, 106, 107, 108 115, 116, 117, 118, 119, 120, 126, 127, 128, 129, 130
Tuesday May 4 8:30 a. m.	Pediatrics Radiology	Tower Room Art Gallery	
Tuesday May 4 8:30 a. m.	General Medicine General Surgery Eye, Ear, Nose and Throat Dermatology and Syphilology Industrial Medicine and Surgery Neuropsychiatry Pathology and Bacteriology Urology	Grill Room Auditorium Copper Cup Room Directors' room Art Gallery Play Room Billiard Room Tower Room	6, 7, 8, 9 27, 28, 29, 30, 31, 32 53, 54, 55, 56 80, 81, 82, 83, 84, 85 86, 87, 88, 89 98, 99, 100 109, 110, 111, 112, 113, 114 137, 138, 139, 140, 141, 142
Wednesday May 5 8:30 a. m.	General Medicine General Surgery Obstetrics and Gynecology Eye, Ear, Nose and Throat Anesthesiology Industrial Medicine and Surgery Pediatrics Radiology	Grill Room Auditorium Copper Cup Room Art Gallery Private Dining Room Billiard Room Directors' Room Tower Room	10, 11, 12, 13 33, 34, 35, 36, 37 48, 49, 50, 51, 52 57, 58, 59 65, 66, 67, 68 90, 91, 92, 93 121, 122, 123, 124, 125 131, 132, 133, 134, 135, 136
Wednesday May 5 1:30 p. m.	General Medicine, General Surgery, Obstetrics and Gynecology, Eye, Ear, Nose and Throat, Pathology and Bacteriology, Pediatrics, and Radiology.	Auditorium	14, 15
	Anesthesiology Urology	Copper Cup Room Tower Room	69, 70, 71, 72, 73 143, 144, 145, 146, 147, 148
Thursday May 6 8:30 a. m.	General Medicine General Surgery Eye, Ear, Nose and Throat	Grill Room Auditorium Art Gallery	16, 17, 18, 19, 20 38, 39, 40, 41, 42 60, 61, 62, 63, 64

Sutter Hospital, Sacramento; and Paul Guttman, M. D., Medico-Dental Building, Sacramento.

7. *Moving Pictures of Ureteral-Intestinal Implantation*—Frank Hinman, M. D., Fitzhugh Building, San Francisco.
8. *Hydronephrosis: Renal Circulation*—Frank Hinman, M. D., Fitzhugh Building, San Francisco.
9. *Some Phases of Dentistry Which Are Also of Interest to the Physician*—California State Dental Association.

This exhibit presents some phases of dentistry which are also of interest to the physician, and conditions where the cooperation of the two professions is required for the good of the patient. It includes roentgenograms, specimens, models, charts, etc.

10. *Dental Abnormalities and Their Occurrence in Patients with Endocrine Dysfunction*—Ralph A. Reynolds, M. D., 490 Post Street, San Francisco.

This exhibit will consist of x-ray plates of: Normal jaw bone; normal teeth and normal roots; progressive bone atrophy (osteoporosis); multiple root resorption following previous orthodontic treatment; multiple root resorption without orthodontic treatment; multiple root resorption in hyperpituitarism (acromegaly); hypercementosis; enamel hypoplasia in deciduous and prominent dentition; alveolar resorption, horizontal type; alveolar resorption, vertical type; peg teeth; and plate showing congenital absence of teeth.

The exhibit will consist primarily of x-ray plates with titles showing the type of endocrine disorder found in the same individual with such dental abnormality. There will also be some photographic reproductions of original roentgenograms.

11. *Tuberculosis*—California Tuberculosis Association, 45 Second Street, San Francisco.

The exhibit of the California Tuberculosis Association will feature a display on the subject of tuberculin-testing, consisting of a series of photographs showing the technique of giving the tuberculin test, a diagram schedule illustrated with

photographs showing how Tuberculin P. P. D. is made, and a set of wax models showing a positive and negative reaction and interpreting the meaning of both.

There will also be a display of x-ray films: a series of fifteen, showing active cases of tuberculosis discovered in high school surveys; and a series of one hundred, showing tuberculosis in different stages—pneumothorax, thoracoplasty, and phrenicotomy.

12. *Heart Disease*—California Heart Association, 45 Second Street, San Francisco.

The exhibit of the California Heart Association will feature a moving picture showing the action of the heart, and a display of pathologic specimens.

13. *Peritoneoscopy*—John C. Ruddock, M. D., 1930 Wilshire Boulevard, Los Angeles, and Robert B. Hope, M. D., 1930 Wilshire Boulevard, Los Angeles.

Diagrammatic visualization of the technique; drawings and photographs of various pathologic conditions for which this procedure is used; demonstration of the instrument; report and analysis of experiences in over five hundred cases demonstrated by tables and graphs.

14. *The Use of Autogenous Strips of Fasciata in the Repair of the More Difficult Abdominal Hernias*—Hall G. Holder, M. D., Medico-Dental Building, San Diego.

This exhibit consists of a motion picture on the technique of the Galli operation and additional material comparing the results in different types of hernioplasty.

15. *Experimental Studies on Vitiligo*—Sophie A. Lurie, M. D., 610 South Broadway, Los Angeles.

Dead, lusterless, chalky areas of vitiligo assume a hue of life promptly after treatment begins. They become gradually pinkish, changing to a brighter, livelier appearance. The spot shrinks from the borders. Pigmented pinhead dots appear one by one inside, gradually forming confluent groups, producing larger pigmented areas until ample parts are repigmented.

16. *Contact Dermatitis From Cosmetics*—Franklin I. Ball, M. D., 6253 Hollywood Boulevard, Hollywood.

Dermatitis produced by cosmetics has been only occasionally mentioned in the literature, which might lead one to believe that it is a rare condition. The part cosmetics play in developing a dermatitis is hard to evaluate. It is our impression that eruptions of this nature are not rare, but only exceptional cases consult the dermatologist. Case exhibits of this nature will be presented with photographs and procedure followed for the discovery of the noxious agent.

17. *Photographs of Primary Syphilis and Chancroid*—Irving R. Bancroft, M. D., 523 West Sixth Street, Los Angeles.

Photographs of primary syphilis and lesions suspected of being syphilis, mostly taken at the Los Angeles County Venereal Clinic, show that orthologically typical lesions may not be syphilis, and atypical lesions may be syphilis, and that negative darkfield examinations should be followed by repeated Wassermann tests.

18. *Facial Scars or Blemishes and the End-Result of Treatment*—H. C. L. Lindsay, M. D., 599 East Colorado Street, Pasadena.

Removal of facial defects from new growth, disease, accidents, or scars, falls within the scope of dermatologists. Raised scars offer less difficulty in the way of improvement than either sunken scars or raised keloids. Simple methods, including minor surgery and physiotherapy, are used to obtain results illustrated.

19. *A New Spirochete Stain*—Stanley O. Chambers, M. D., Roosevelt Building, Los Angeles.

Demonstration, microscopic and photographic, of the technique of the spirochete stain, using photographs of the tissue and application of the same comparative data from a review of one hundred cases of primary syphilis wherein the stain has been used for diagnosis in comparison with the darkfield procedure.

20. *Acne Conglobata of the Buttock Relieved by Cautery*—George F. Koetter, M. D., 1136 West Sixth Street, Los Angeles.

Acne conglobata treated by cautery; clinical photographs.

21. *Grass Dermatitis*—Saul S. Robinson, M. D., 1930 Wilshire Boulevard, Los Angeles.

This exhibit consists of photographs descriptive of the erythematous, vesicular, bullous and pigmented lesions found in grass dermatitis. Many cases of grass dermatitis have been recorded during the past ten years in Europe, especially by the Oppenheim Clinic in Vienna. The patient presented is one of the first cases of this disorder to be reported in California.

22. *Congenital Anomalies of the Skin*—Samuel Ayres, Jr., M. D., 2007 Wilshire Boulevard, Los Angeles; Nelson P. Anderson, M. D., 2007 Wilshire Boulevard, Los Angeles; and Paul D. Foster, M. D., 2007 Wilshire Boulevard, Los Angeles.

An exhibit of clinical photographs of various types of congenital defects, including anomalies of pigmentation, vascular tissue, elastic tissue, etc.

23. *Association of California Hospitals Educational Ex-*

hibit—The Trustees of the Association of California Hospitals.

This exhibit will offer a chart, outlining the Association's aims and objectives. A chart and descriptive material on hospital medical social service, and other educational features of interest to the medical profession will be available.

24. *Favus—Clinical and Mycological Studies*—Norman N. Epstein, M. D., 450 Sutter Street, San Francisco, and Edward A. Levin, M. D., 450 Sutter Street, San Francisco.

Photographs demonstrating the clinical features of true favus infection due to *Achorion schoenleinii*, with report of a case involving the scalp and nails.

Demonstrated also will be photomicrographs, showing the infected hairs as well as gross culture of the more common types of the *Achorion* group of ringworm.

25. *Benign and Malignant Histological Specimens*—Eric G. Liljencrantz, M. D., Stanford University Hospital, San Francisco, and George V. Kulchar, M. D., 450 Sutter Street, San Francisco.

Various dermatoses clinically simulating epithelioma which on histologic examination proved to be benign, and lesions which clinically appeared benign but on histologic examination proved to be malignant, are exhibited. The technique of x-ray therapy of cutaneous malignancies is illustrated.

26. *Peptic Ulcer*—Harold Lincoln Thompson, M. D., F. A. C. S., 1930 Wilshire Blvd., Los Angeles.

This exhibit on gastric ulcer includes statistical clinical data—pathologic specimens, diagrams, and charts—on peptic ulcer, with especial emphasis on acute perforation and methods and results of treatment.

27. *Plastic Surgery: Before and After*—Fred Lindenberg, M. D., 1680 North Vine Street, Hollywood.

28. *The Injection and Operative Treatment of Hernia*—Leigh F. Watson, M. D., 727 West Seventh Street, Los Angeles.

The injection treatment for the cure of selected cases of reducible hernia represents an important economic saving to industry. The importance of using an injection fluid that does not cause much pain as shown in the end-results. Charts and drawings. New fascia transplant operations for large hernias.

29. *Reconstructive Surgery*—Arthur E. Smith, M. D., D. D. S., 1930 Wilshire Boulevard, Los Angeles, and James B. Johnson, M. D., 1930 Wilshire Boulevard, Los Angeles.

Over two hundred illuminated transparent photographs will be shown of numerous reconstructive surgery cases. Many of the transparencies are hand-painted.

30. *Skin Malignancies*—William H. Sargent, M. D., Samuel Merritt Hospital, Oakland.

31. *Anomalies of the Spine*—R. A. Carter, M. D., Los Angeles General Hospital, Los Angeles.

32. *Irradiation Therapy*—R. A. Carter, M. D., Los Angeles General Hospital, Los Angeles.

33. *A New Amputation Through the Femur at the Knee*—C. Latimer Callander, 450 Sutter, San Francisco.

Exhibit consists of surgically dissected specimens prepared by a special process for permanency.

V—ENTERTAINMENT

Tuesday, May 3

Sunday Afternoon:

Annual North and South Golf Tournament. This is in addition to the Tuesday afternoon golf tournament.

Tuesday Afternoon:

Golf; skeet-shoot; automobile drives—Monterey Bay.

Tuesday Evening:

President's dinner and ball, 7:30 p. m., main dining room.

Entertainment in the ballroom, 9:30 p. m.

Dancing, 10:30 to 1:00 a. m.

Guests registered in Hotel Del Monte must secure dinner tickets from the Hotel Management.

Guests registered at other hotels or lodging places around Monterey Bay must secure dinner tickets at the registration desk *before noon, May 3*. Price, \$2.50 per plate.

The Management announces that it will be unable to make any special table reservations unless requests are made to the assistant manager.



MRS. ANDREW J. THORNTON
President, Woman's Auxiliary to the
California Medical Association
1936-1937



MRS. HOBART ROGERS
Secretary, Woman's Auxiliary to the
California Medical Association
1936-1937

VI—WOMAN'S AUXILIARY

Eighth Annual Session

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

Headquarters at Hotel Del Monte, Del Monte

MRS. ANDREW J. THORNTON, *President*

MRS. JOHN HUNT SHEPARD, *Convention Chairman*

Sunday, May 2

- Arrival of delegates, members and guests, greeted by delegation hostesses.
3:00-5:00 p.m.—Registration at registration desk.
4:00 p.m.—Informal tea—Hotel Del Monte.
7:30-9:30—Registration.

Monday, May 3

- 8:45 a.m.—Pre-Convention State Board meeting in Tower Room, Hotel Del Monte.
9:00 a.m.-4:00 p.m.—Registration.
10:00 a.m.—First general meeting of the California Medical Association. All Auxiliary members and wives of doctors are invited to attend.
12:30 p.m.—Informal luncheon at Hotel Del Monte, with local hostesses presiding.
2:00 p.m.—Motor trips to interesting points on the Monterey Peninsula.
9:00 p.m.—Reception and musicale in honor of Mrs. Edward M. Pallette, wife of the president of the California Medical Association, to be held in the Copper Cup Room of the Hotel Del Monte. Members of the State Board will serve on the Reception Committee.

Tuesday, May 4

- 9:00 a.m.-1:00 p.m.—Registration.
9:30 a.m.—First general session of the eighth annual convention at Del Monte Lodge, Mrs. Andrew J. Thornton presiding.
1:00 p.m.—Luncheon at Del Monte Lodge honoring Mrs. Andrew J. Thornton, with Mrs. Thomas J. Clark presiding. Members of the State Advisory Board will be guests of honor.
7:30 p.m.—President's dinner and dance of the California Medical Association at Hotel Del Monte.

Wednesday, May 5

- 9:00-11:00 a.m.—Registration.
9:30 a.m.—Second general session of the eighth annual convention at Del Monte Lodge, Mrs. Andrew J. Thornton presiding. Election of officers.
12:30 p.m.—Post-Convention State Board meeting.
1:30 p.m.—The Seventeen-Mile Drive.
1:30 p.m.—Women's Golf Tournament.
4:00 p.m.—Musical tea, Monterey Peninsula Country Club, in honor of Mrs. Robert E. Fitzgerald, national president, and the incoming president, Mrs. Hobart Rogers, and the past presidents.

President's Report

To the Members of the Auxiliary:

The Woman's Auxiliary to the California Medical Association has had a busy and profitable year. Early in the fall, the State President outlined the following four-point program to the county organizations:

1. A membership drive with the twofold objective of renewing the interest of lapsed members and attracting new ones.

2. A careful study of the various aspects of socialized medicine, animal experimentation, and the educational standards of all types of professional schools whose graduates may practice the healing art in California.

3. An active sponsorship of *Hygeia*.

4. A contribution to the health education of the community through a Public Health Day or Institute.

The cooperation received has been most gratifying. For example, Santa Barbara County conducted a successful three-day Health Institute and to date San Diego County has increased its membership 41 per cent.

Good work has been done in behalf of *Hygeia*, but since the records from all the counties are not at hand

a report of the number of subscriptions obtained cannot be given.

The Woman's Auxiliary is making a place for itself in the life of the community, and is being called upon more and more to assist in the programs of other health agencies. We feel this marks a step forward.

These are a few of the projects undertaken by the individual counties: an essay contest in the public schools, organization of the assembly districts, a health activities contest for parent-teacher associations with twenty subscriptions to *Hygeia* as prize for the winner, assistance in the examination of school

children for tuberculosis, coöperation in the Health Education program of the Y. W. C. A.

In addition, each Auxiliary has undertaken some philanthropic work. The State Board has acquired a collection of books and health plays which it is hoped will be the nucleus of a Lending Library for the use of county auxiliaries and other groups in preparing health education programs.

These achievements were made possible by the enthusiasm of the individual members and the helpful counsel of the Advisory Board of the California Medical Association, for both of which I am deeply grateful.

MRS. ANDREW J. THORNTON, *President*.

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

CONVENTION COMMITTEES

Mrs. John Hunt Shephard, General Chairman

Credentials and Registration

Mrs. Willard H. Newman, Chairman
Mrs. A. J. Baiocchi, Local Chairman
Mrs. George Gray, Vice-Chairman
Mrs. J. P. Lovely, Mrs. Russell E. Lee
Mrs. J. I. Beattie, Mrs. Don Carlos Hines

Information

Mrs. Garth Parker, Chairman
Mrs. Roy M. Fortier

Transportation and Sightseeing

Mrs. A. A. Arehart, Chairman
Mrs. Rudolph O. Griess, Vice-Chairman
Mrs. Howard E. Clark

Hospitality

Mrs. H. E. Dahleen, Chairman
Mrs. Charles E. Moore, Vice-Chairman
Mrs. Thomas L. Blanchard, Mrs. Hyman Tucker
Mrs. James Bullitt, Mrs. E. A. Turco
Mrs. Cecil Burchfiel, Mrs. Mark Hopkins
Mrs. Dudley Fagerstrom, Mrs. F. C. Gerlach
Mrs. Bart Gattuccio, Mrs. M. W. Kapp
Mrs. L. S. Moore, Mrs. Bert Loehr
Mrs. E. W. Mullen, Mrs. Max Hawley
Mrs. J. Porter, Mrs. Clyde Wayland
Mrs. C. S. Sullivan, Mrs. Tolbert Watson
Mrs. F. W. Slattery

Entertainment

Mrs. H. Spencer Hoyt, Chairman
Mrs. Charles M. Richards, Vice-Chairman
Mrs. H. N. Yates, Chairman of Reception and Musicales
Mrs. E. P. Cook, Vice-Chairman of Reception and Musicales
Mrs. James H. McPharlin, Chairman of Luncheon
Mrs. Horace F. Dormody, Mrs. F. Hilton Smith
Mrs. Frank Wiebe
Mrs. John P. Sandholdt, Chairman of Tea
Mrs. William M. Gratiot, Mrs. R. A. Workman
Mrs. H. W. Milo, Chairman of Golf Tournament
Mrs. Robert Powers, Vice-Chairman of Golf Tournament

Decorations and Flowers

Mrs. John Gratiot, Chairman
Mrs. R. D. Mace, Mrs. Werner D. Meyenberg

Headquarters

Mrs. W. H. Farr, Chairman
Mrs. J. C. Sharp, Vice-Chairman
Mrs. Raymond V. Rukke, Mrs. Joseph B. McCarthy

Ushers and Pages

Mrs. Arthur L. Wessels, Chairman
Mrs. Winton F. Swengel, Mrs. Edwin F. Kehr

Supplies and Printing

Mrs. C. Kelly Canelo, Chairman
Mrs. J. P. Rutherford, Vice-Chairman
Mrs. C. P. Durney, Mrs. E. A. Rouff

Finance

Mrs. R. S. Kneeshaw, Chairman
Mrs. Merlin Maynard, Vice-Chairman
Mrs. Horace Jones, Mrs. Karl Pelkan
Mrs. J. H. Kirk, Mrs. Phillip Wise

Publicity

Mrs. M. D. Baker, Chairman
Mrs. F. N. Chilton, Vice-Chairman
Mrs. L. M. Rose, Mrs. S. B. Van Dalsem

Emergency and Aids to General Chairman

Mrs. Paul Martin, Chairman
Mrs. Dan Brodovsky, Vice-Chairman
Mrs. Edward Amaral, Mrs. Charles Ianne
Mrs. Daniel Bilker, Mrs. J. B. Josephson
Mrs. H. Barrette, Mrs. Louis Lackner
Mrs. M. A. Broemser, Mrs. Russell Kapp
Mrs. Irving Cassell, Mrs. A. J. Monty
Mrs. H. A. Cilley, Mrs. Paul Pace
Mrs. A. R. Currin, Mrs. L. E. Phillips
Mrs. H. G. Diesner, Mrs. E. O. G. Schmitt
Mrs. Stanley Dougan, Mrs. B. H. Wardrip
Mrs. William R. Harder, Mrs. J. C. Wilson



During the summer months many of Del Monte's sport activities center around the Roman Plunge, which is but a few steps from the entrance to the Hotel.

VII—HOTEL AND RAILROAD INFORMATION

HOTEL RATES

HOTELS—DEL MONTE—1937 ANNUAL SESSION

The following arrangements have been made for hotel accommodations for our annual session in Del Monte, May 2-6, 1937.

1. Hotel Del Monte will be general headquarters.
2. All hotel reservations will be made by and through Mr. Carl Stanley, manager of Hotel Del Monte.
3. Members will select the accommodations desired in the following list of hotels and then request Mr. Stanley to obtain and confirm them.
4. Do not write to the hotels. *Write only to Mr. Stanley*, who is in sole charge of hotel reservations.

Hotels at Del Monte and Pebble Beach

HOTEL DEL MONTE, DEL MONTE, CALIFORNIA

Rates, American Plan. Accommodations for between 650 and 700 persons

Both Wings:	Per Day
Single room without bath, one person.....	\$7.50
Double room without bath, two persons.....	7.00
Single room with bath, one person.....	8.50
Double room with bath, two persons.....	7.50
Two single rooms, bath between, two persons.....	8.00
Two double rooms, bath between, four persons.....	7.00

Main Building, Cottages and Remodeled Wing Rooms:

Single room with bath, one person.....	\$9.50
Double room with bath, two persons.....	8.50
Sitting room.....	7.00

✓ ✓ ✓

DEL MONTE LODGE—SAME MANAGEMENT AS HOTEL DEL MONTE
PEBBLE BEACH, CALIFORNIA

The Lodge is located approximately five miles from the Del Monte Hotel. *European Plan*

Main Building:

16 twin bedded rooms with bath from..\$5.00 to \$10.00 single
6.00 to 12.00 double

1 room, single only, with shower bath.. 6.00
1 room, single only, with tub & shower.. 6.00
1 corner suite-parlor, twin beds,
bath.....\$16.00 single—\$20.00 double

Cottage Row:

Two cottages consisting of four bedrooms each, two
baths and a sitting room, accommodating eight
persons.....\$40.00

Ten individual bedrooms, medium sized, alternating
with tub and shower baths, mostly twin beds—
some with double beds:

Single	7.00
Double	9.00

(Accommodations for approximately 70 at the Lodge.)

Hotels in Carmel, California

PINE INN, CARMEL, CALIFORNIA

Located in the heart of Carmel

Can accommodate from 150 to 200 persons

Room with twin beds and bath.....	\$4.00 single
	5.00 double
Rooms with twin beds and bath.....	3.50 single
	4.00 double
Rooms, double beds, without bath—hot and cold running water.....	2.00 single
	2.50 double
4 cottages (1 double and 1 single bed).....	4.00 single
	5.00 double
2 cottages (1 double and 1 single bed).....	8.00 double
	9.00—3 persons
4 cottages with 3 bedrooms and sitting room—4 or 6.....	15.00
Meal Rates—	
Dinner, 85c; Luncheon, 65c; Breakfast, 35c and 50c	

✓ ✓ ✓

HOTEL LA RIBERA, CARMEL, CALIFORNIA

Located in the heart of Carmel—approximately five miles
from Hotel Del Monte

Can accommodate approximately 65 persons

Twin bedded rooms with bath.....	\$5.00 per day
Twin bedded rooms without bath.....	3.50 and \$4.00 per day
Double-bed rooms with bath.....	3.00 single
	4.00 double
Double-bed rooms without bath.....	2.00 single
	3.00 double

HIGHLAND INN, CARMEL, CALIFORNIA

Located four miles south of Carmel—approximately seven
miles from Hotel Del Monte (European plan)

Accommodations for approximately 80 to 100 persons

Half the accommodations with twin beds and half with
double beds

Rates—Single	\$3.50 per day
Rates—Double	4.00, 5.00 and 6.00 per day

✓ ✓ ✓

LA PLAYA HOTEL, CARMEL, CALIFORNIA

European Plan

Located in the heart of the town

Can accommodate approximately 9 persons

Main Building:

Rooms with twin beds and bath.....	\$3.00, \$3.50, \$4.00 single
	5.00, 6.00, 7.00 double
Rooms with double bed and bath.....	3.00, 3.50, 4.00 single
	4.50, 5.00, 5.50 double
Rooms with double and single bed and bath.....	3.00, 3.50, 4.00 single
	4.50, 5.00, 5.50 double
Suites of two rooms each—twin beds and bath between.....	3.00, 3.50 single
	4.50, 5.00 double

In Bungalow:

Two suites of two rooms, twin beds and bath between	2.50 single
	4.00 double

One suite of three rooms, two double and one pair twin beds, one bath.....	2.00 single
	3.50 double

Meal Charges—

Breakfast, 75c; Luncheon, \$1.00; Dinner, \$1.00.

Where three rates are shown, the lower is without ocean
view, the next with partial view, the highest with full
view.

Hotels in Monterey, California

HOTEL MONTEREY, MONTEREY, CALIFORNIA

Located in the heart of town—one mile from
Hotel Del Monte. *European plan*.

Can accommodate approximately 58 persons

Rooms with bath, single.....	\$2.50 per person
Rooms with bath, double.....	3.50 per person
Rooms without bath, single.....	2.00 per person
Rooms with bath, double.....	2.50 per person

Two of the twelve rooms with bath have two double
beds each; these are family suites with two connecting
rooms with bath off one of the rooms. These rent as
follows:

Two persons.....	\$4.00
Three persons.....	5.00
Four persons.....	6.00

✓ ✓ ✓

HOTEL SAN CARLOS, MONTEREY, CALIFORNIA

Located in the heart of Monterey—one mile from
Hotel Del Monte. *European plan*

Can accommodate approximately 150 persons

Double rooms—double beds and shower baths.....	\$4.50
Double rooms—double beds and tub baths.....	4.50
Twin-bedded rooms, having tub baths.....	6.00
Twin-bedded rooms, having tub baths.....	7.00

✓ ✓ ✓

MISSION INN, MONTEREY, CALIFORNIA

Located in the heart of Monterey, Calif.—one mile from
Hotel Del Monte. *European plan*

Can accommodate approximately 85 persons

Rooms with private baths.....	\$3.00 single
	4.00 double
	4.00 & 5.00 twin beds
Three suites consisting of two rooms with bath.....	1.50 to 2.25 per person
	(Depending upon the number occupying suite)
Rooms (double beds) without bath..	1.50 single
	2.00 double

Hotels in Pacific Grove, California

FOREST HILLS HOTEL

Located in Pacific Grove, California, approximately four miles from Hotel Del Monte. *European plan*

Can accommodate approximately 100 persons
 Double rooms with bath (two persons).....\$3.50 per day
 Twin-bedded rooms with bath (two persons).. 4.50 per day

♦ ♦ ♦

ASILOMAR—PACIFIC GROVE, CALIFORNIA

Located in Pacific Grove—about six miles from Hotel Del Monte. *European plan*

Can accommodate 157 persons

The Lodge contains twenty-one rooms with a guest capacity of twenty-eight

3 doubles with connecting tub bath..... \$3.00 per person
 1 double with private toilet and balcony.... 3.00 per person
 3 doubles with connecting toilets..... 2.00 per person
 10 singles with connecting toilets..... 2.00 per person
 4 singles convenient to toilet..... 2.00 per person
 (All rooms have hot and cold running water and there

is a large, comfortable living room with open fireplace in the lodge.)

Scripps contains thirty rooms with a capacity of thirty-nine guests

4 doubles with connecting toilets and tubs..\$3.00 per person
 4 doubles with connecting toilets and show-
 ers 2.50 per person
 1 double with private toilet and shower.... 2.50 per person
 21 singles with connecting toilets and
 showers 2.50 per person

(All rooms have hot and cold running water and there is a comfortable living room with open fireplace in Scripps.)

Guest Inn contains forty rooms and accommodates ninety guests

10 rooms to accommodate three persons
 each\$1.00 per person
 30 doubles 1.50 per person

(In this building the toilets, showers and tubs are all detached, there is no running water in the rooms. There is a comfortable living room with open fireplace.)

Breakfast, 35c, 40c and 50c; luncheon, 65c; dinner, 85c.

RAILROAD INFORMATION*

May 2–6, 1937

Ticket Agents of principal rail lines in California, on presentation and surrender of identification certificates, will sell round-trip tickets to Del Monte or Monterey, Calif., costing approximately 1¼c per mile, which is less than the first-class one-way fare. Tickets will be sold from April 28 to May 6, inclusive, and return limit will be May 16, 1937. Stopovers allowed. If longer return limit is desired, consult railroad ticket agent at Del Monte or Monterey prior to May 16, 1937.

Following are examples of fares to Del Monte and illustrate the extent of reduction:

From	One Way 1st Class	One Way Coach	Convention R. T. (85%)	30-Day R. T. Coach	21-Day R. T. 1st Class
San Francisco	\$ 3.70	\$2.47	\$3.15	\$ 4.45	\$ 4.90
San Jose	2.25	1.50	1.95	2.70	3.00
Los Angeles	11.45	7.64	9.75	13.76	15.15

Send a stamped, self-addressed envelope to the State Secretary to secure a certificate in order to obtain convention rate, which is an 85 per cent reduction.

RAILROAD SERVICE

	DAYLIGHT	DEL MONTE EXPRESS	COASTER		DAYLIGHT	COASTER
Leave San Francisco.....	8:15 a. m.	4:00 p. m.	6:15 p. m.	Leave Santa Barbara	10:35 a. m.	9:05 p. m.
Arrive Del Monte.....	11:09 a. m.	6:50 p. m.	9:49 p. m.	Arrive Del Monte.....	4:11 p. m.	7:45 a. m.
	DAYLIGHT	COASTER			SANTA FE	
Leave Los Angeles.....	8:15 a. m.	6:05 p. m.		Leave San Diego.....	1:00 a. m.	2:00 p. m.
Arrive Del Monte.....	4:11 p. m.	7:45 a. m.		Arrive Los Angeles.....	5:00 a. m.	5:15 a. m.

Service afforded by Daylight Limited, the Del Monte and Coaster from San Francisco. Service from Southern California by Daylight Limited and Coaster.

* What is here given is printed for its general informative value. It is wise to check on your own ticket rates and time tables.



Best known of the many scenic spots along Del Monte's famous Seventeen-Mile Drive is Midway Point with the Lone Cypress.

VIII—SECTION MEETINGS

SCIENTIFIC SECTION PROGRAMS

(Numbers in parenthesis after each section indicate sequence reference numbers of papers read in each section.)

I.—General Medicine (1-20).....	19
II.—General Surgery (21-42).....	21
III.—Obstetrics and Gynecology (43-52).....	23
IV.—Eye, Ear, Nose, and Throat (53-64).....	24
V.—Anesthesiology (65-73).....	26
VI.—Dermatology and Syphilology (74-85)....	27
VII.—Industrial Medicine and Surgery (86-93).....	28
VIII.—Neuropsychiatry (94-100).....	29
IX.—Pathology and Bacteriology 101-114)....	30
X.—Pediatrics (115-125).....	31
XI.—Radiology (126-136).....	32
XII.—Urology (137-148).....	33

Rules Regarding Papers and Discussions at the State Meetings:

Upon the recommendation of the Executive Committee the following rules regarding papers have been adopted by the Council:

1. The maximum time that may be consumed by any paper is fifteen minutes, provided that not to exceed ten minutes' latitude may be allowed invited guests at the discretion of the presiding chairman.
2. Motions from the floor to extend the time of an author may be entertained by the presiding officer.
3. The maximum time permitted any individual to discuss a paper is four minutes. This also applies to the author in closing his discussion. No speaker may discuss more than once any one subject.
4. A copy of each and every paper presented at the state meeting must be in the hands of the chairman or secretary of the section or in the hands of the general secretary before the paper is presented.
5. All papers read at the annual meeting shall be published in full in CALIFORNIA AND WESTERN MEDICINE as soon after the meeting as space will permit, or at the option of the author, an abstract of the paper of about one column in length shall be published as soon as possible after the meeting, with reprints in full of the entire paper (the cost of setting up type for the reprint to be borne by the Association, and all other costs to be borne by the author).
6. Articles are accepted for publication on condition that they are contributed solely to CALIFORNIA AND WESTERN MEDICINE. Authors desiring to publish their papers elsewhere than in the JOURNAL may have their manuscripts returned to them upon written request to the State Secretary.
7. No paper will be accepted by the General Program Committee nor by Section Program Committees unless accompanied by a synopsis of not to exceed fifty words.
8. Papers shall not be "read by title."
9. No member may present more than one paper at any one state meeting, provided that a member may be a collaborator on more than one paper, if these papers are presented by different authors.
10. Failure on the part of an author to present a paper precludes acceptance of future papers from such author for a period of two years, unless the author explains to the satisfaction of the Executive Committee his inability to fulfill his obligation.

Number of Section Papers

For convenience in reference, papers are numbered in serial sequence for the entire session, instead of a separate sequence for each section.

Business Meeting of Sections

Time of business meetings and elections of officers of sections will be scheduled on section blackboards by section secretaries, and through preliminary announcements by section chairmen.

Unless otherwise announced, the business meetings of each section and the election of officers will be held immediately after the reading of the second paper on the second day's section program.

I

GENERAL MEDICINE SECTION

JOHN C. RUDDOCK, M. D., *Chairman*
1930 Wilshire Boulevard, Los Angeles

EDWIN L. BRUCK, M. D., *Secretary*
384 Post Street, San Francisco

First Meeting—Grill Room

Monday, May 3, 1:30 p. m.

1. *Gastric Ulcer: Indications for Medical or Surgical Treatment*—William C. Boeck, M. D., 1919 Wilshire Boulevard, Los Angeles.

The incidence of gastric ulcer is estimated to be about one-tenth that of duodenal ulcer, but while it occurs so much more infrequently, its clinical importance is inversely magnified. This is due to the fact that it must be differentiated from carcinoma. The question of medical treatment and operative interference involves a grave responsibility, and data are presented relating to this problem.

Discussion by Clarence G. Toland, M. D., Los Angeles; Fred H. Kruse, M. D., San Francisco.

2. *Functional Indigestion*—Alfred E. Koehler, M. D., 317 West Pueblo Street, Santa Barbara.

These studies are concerned with digestive disturbances in cases where organic lesions have been ruled out but where disturbances in gastro-intestinal motility, deficiencies in digestive secretions, and impairment of absorption are disturbing factors. Endocrine and autonomic nervous system regulation of these functional factors is discussed. The method of treatment is presented.

Discussion by William C. Boeck, M. D., Los Angeles; Hugh F. Freidell, M. D., Santa Barbara.

3. *The Effect of Cigarette Smoking on the Concentration of Acidity and the Volume of the Gastric Juices, with Particular Reference to Peptic Ulcer*—Harold H. Rosenblum, M. D., 450 Sutter Street, San Francisco.

The effect of the smoking of a cigarette on the acidity and volume of the gastric juice was determined in fasting patients with and without peptic ulcer. Comparison was made between the response in the gastric juice to smoking and the response to the administration of 50 cubic centimeters of 7 per cent alcohol.

Discussion by Arthur Bloomfield, M. D., San Francisco.

4. *Chairman's Address: Peritoneoscopy, Its Clinical Applications*—John C. Ruddock, M. D., 1930 Wilshire Boulevard, Los Angeles.

A short history of the development of the procedure of peritoneoscopy; description of the technique; contra-indications; selection of suitable cases; dangers of the procedure; analysis of over five hundred cases examined by this method.

Discussion by Lyle G. McNeile, M. D., Los Angeles; Clarence G. Toland, M. D., Los Angeles.

5. *The Diagnosis of the Unusual Appendix*—John V. Barrow, M. D., 1930 Wilshire Boulevard, Los Angeles.

Minimal pathology in the appendix initiates minimal symptom response. The clinical manifestations vary in intensity and in location so much that the so-called typical onset is not even imitated.

The average appendix recognized as acute is just another acute exacerbation on the chronic pathology. There is a typical clinical history leading up to the appendiceal tragedy, but the whole picture is badly named.

Discussion by William H. Olds, M. D., Los Angeles; Clarence G. Toland, M. D., Los Angeles.

Second Meeting—Grill Room

Tuesday, May 4, 8:30 a. m.

6. *Simonds' Disease—Hypophyseal Cachexia*—Roberto F. Escamilla, M. D., 384 Post Street, San Francisco; and Hans Lisser, M. D., 384 Post Street, San Francisco.

Simonds' disease is considered due to impaired function of the anterior pituitary. It is diagnosed clinically chiefly by (1) loss of weight, progressing to emaciation; (2) disturbance of sexual function; (3) definitely lowered basal metabolism, together with other characteristic but less constant findings. Treatment with anterior pituitary preparations is discussed.

Discussion by C. K. Canelo, M. D., San Jose; Lewis T. Bullock, M. D., Los Angeles.

7. *Clinical Experiences and Experiments with Protamin Insulin*—James W. Sherrill, M. D., Scripps Metabolic Clinic, La Jolla.

From the clinical standpoint, protamin insulin is a distinct improvement over the regular type of insulin. Although the number of injections required is not reduced, the diabetic patient can now be kept in a nondiabetic state over the greater part of the twenty-four-hour day. The effect of protamin insulin in diabetics of varying degrees of severity and various states of nutrition is discussed. The effect of various types of diet with relation to protamin insulin is also discussed.

Discussion by Howard F. West, M. D., Los Angeles; H. C. Shepardson, M. D., San Francisco.

8. *Pulmonary Involvement in Lymphosarcoma and Lymphatic Leukemia*—Ernest H. Falconer, M. D., 384 Post Street, San Francisco.

In 1935, twenty-nine cases of Hodgkin's disease were surveyed for evidence of pulmonary involvement. A report was compiled and published on the basis of these statistics. As part of this study the patients with lymphosarcoma and lymphatic leukemia treated either in the University of California Hospital or in the out-patient department between the years 1923 and 1936 are studied for evidence of pulmonary involvement. This report is based on a study of these cases from the clinical, roentgenologic and pathologic aspects.

Discussion by Paul Michael, M. D., Oakland; Robert Stone, M. D., San Francisco.

9. *Some Physical Phenomena Associated with Anxiety States and Their Relationship to Hyperventilation*—William J. Kerr, M. D., Paul A. Gliebe, M. D., and James M. Dalton, M. D. (by invitation), University of California Hospital, San Francisco.

The influence of emotional stress upon the individual is apparent to physicians, and even to laymen. The physiologic disturbances associated with anxiety states or resulting from them are not so well appreciated by any but the most skilled physicians. The functional disturbances which are due to altered physiologic states cause the symptoms, as we have been able to demonstrate. Biochemical changes are the result as well as the cause of altered function. The interactions in the individual augment the anxiety state and continue the symptoms.

Discussion by D. Schuyler Pulford, M. D., Sacramento; Frank R. Nuzum, M. D., Santa Barbara.

RECESS

Business meeting and election of officers.



Third Meeting—Grill Room

Wednesday, May 5, 8:30 a. m.

10. *Aleukemic Myelosis (Aleukemic Leukemia), with Special Reference to the Clinical Significance of the Myeloblast: Report of Twenty-One Cases*—Stacy R. Mettier, M. D., and Katherine Purviance, A. B. (by invitation), University of California Medical School, San Francisco.

The occurrence of immature leukocytes in the peripheral blood often occasions diagnostic difficulty. Especially is this true when associated with leukopenia and anemia. This is a report of twenty-one selected cases in which the myeloblast comprised from 2 to 80 per cent of the total circulating leukocytes. These cases were diagnosed aleukemic leukemia. The important clinical manifestations and laboratory data are discussed.

Discussion by B. O. Raulston, M. D., Los Angeles; A. G. Foord, M. D., Pasadena.

11. *Atypical Vincent's Infection Manifesting Itself as a Systemic Disease*—William H. Barrow, M. D., 1400 Medico-Dental Building, San Diego.

A series of cases is presented of Fusio-spirochetal infection of the mouth and throat without the usual easily recognizable local lesions, but with moderately severe symptoms of a general systemic reaction. These symptoms are described and tabulated. The differentiation between normal and pathologic oral spirochetosis is discussed. The possibility of the existence of an allergic sensitivity to bacterial toxins or endotoxins is suggested by the occurrence of urticaria in some of the cases. Treatment and its results are outlined briefly.

Discussion by A. Herman Zeiler, M. D., Los Angeles; Hiram Miller, M. D., San Francisco.

12. *Treatment of Thrombocytopenic Purpura Hemorrhagica with Massive Doses of Moccasin Snake Venom: Report of a Case with Complete Recovery in Four Days and Review of the Literature*—Carlyle P. Imerman, M. D., 802 Taft Building, Hollywood.

Male, age forty-seven, with extreme pyorrhea, Vincent's angina and caries of the teeth, had hemorrhages from gums for two weeks. Carious teeth were extracted and five cubic centimeters dose of snake venom administered. Platelet count rose from 18,660 to 231,000 in four days. It is plausible that the suggested doses of snake venom are inadequate in certain cases.

Discussion by Ernest H. Falconer, San Francisco; Verne R. Mason, Los Angeles.

13. *The Significance of Changes in the White Blood Cells in Various Diseases*—Cyrus C. Sturgis, M. D., University of Michigan, Ann Arbor, Michigan. (By invitation.)

Consideration will be given to our present-day conception of the origin and function of the different types of white blood cells and the changes which occur in them in various disease conditions. The discussion will include the response of the leukocytes to different infections and a consideration of the variations of these cells from the standpoint of diagnosis, prognosis, and treatment in the leukemias, infectious mononucleosis, and agranulocytic angina.



Fourth Meeting—Auditorium

Wednesday, May 5, 1:30 p. m.

SYMPOSIUM ON PNEUMONIA

14. *Management of the Pneumonias*—Jesse G. M. Bullock, M. D., New York University College of Medicine, New York. (By invitation.)

Pneumonia will be discussed from the standpoint of a specific infection. Pneumonia described according to bacteriologic classification rather than anatomically. Therapy by use of specific therapeutic agents will be described in detail.

15. *Empyema, Interlobar and General*—Harold Brunn, M. D., 384 Post Street, San Francisco.

Acute empyema will be discussed mainly from the standpoint of errors that have been made in cases presenting themselves at the University of California Thoracic Clinic and their resultant com-

plications; also a résumé of the methods of treatment inaugurated in various stages of the diseases.

Interlobar empyema will be discussed from the standpoint of modes of infection, diagnosis, and treatment.

The subject will be discussed for the most part with lantern slides.

Discussion by H. Edward Stafford, M. D., Oakland; Lowell S. Goin, M. D., Los Angeles; A. M. Moody, M. D., San Francisco; David A. Wood, M. D., San Francisco; H. E. Schiffbauer, M. D., Los Angeles; E. J. Krahulik, M. D., Los Angeles; Clyde Harner, M. D., Long Beach; Harold Fletcher, M. D., San Francisco.



Fifth Meeting—Grill Room

Thursday, May 6, 8:30 a. m.

16. *A Dynamic Approach to Pulmonary Tuberculosis*—Harold G. Trimble, M. D., 707 Latham Square Building, Oakland, and Bulford Wardrip, M. D., San Jose.

Understanding that adequate rest is essential to promote healing, it is obligatory to control the mechanical problem in the chest. A résumé of various types of collapse procedures as they are commonly used by us is presented; their indications, combinations, and what we may reasonably expect to accomplish from them.

Discussion by Sidney J. Shipman, M. D., San Francisco; Carl Howson, M. D., Los Angeles.

17. *A Review of Tuberculous Tracheobronchitis*—Philip H. Pierson, M. D., 490 Post Street, San Francisco, and Paul C. Samson, M. D., 411 Thirtieth Street, Oakland. (By invitation.)

The term "tuberculous tracheobronchitis" means specific tuberculous infection of the trachea and bronchi, and is almost always secondary to active parenchymal pulmonary tuberculosis. In an experience with over eighty cases we are convinced of its danger as a complication. The paper will summarize the signs, symptoms, roentgenographic appearance and bronchoscopic findings in tuberculous tracheobronchitis, and will cover the incidence, prognosis, relationship to collapse therapy and the various forms of symptomatic and curative therapy.

Discussion by John C. Jones, M. D., Los Angeles; Sidney J. Shipman, M. D., San Francisco.

18. *The Nutritional Problem in Toxemias of Acute Contagious Diseases*—Milton J. Tobias, M. D., 1052 West Sixth Street, Los Angeles.

A severe toxemic state with its peculiar physical, chemical and energy phenomena, requires a compatible nutritional intake, differing from that of the well individual.

Predicated upon this hypothesis, severe toxemic patients were fed (in addition to high carbohydrate high vitamin diet) an augmented intake of nucleoproteins and lecithin, with salutary results.

Discussion by Hilario Marquez, M. D., San Francisco; A. G. Bower, M. D., Glendale.

19. *A Case of Extreme Obesity, Amenorrhea, Hypertension, and Diabetes Mellitus Successfully Treated with Anterior Pituitary Sex Hormones*—William M. Moffatt, M. D., The Santa Barbara Clinic, Santa Barbara.

Lantern slides are used to show the apparent effects of treatment on the weight, basal metabolism, pulse rate, periods of uterine bleeding, glucose tolerance, glycosuria, glycemia, and blood pressure, over a period of eighteen months. The syndrome is discussed and some of the possible explanations of results of treatment are suggested.

Discussion by Hans Lisser, M. D., San Francisco; P. A. Gray, Jr., M. D., Santa Barbara.

20. *The Value of Repeated Fundus Oculi Studies to Better Diagnosis and Treatment in General Medicine*—George L. Kilgore, M. D., Bank of America Building, San Diego.

An attempt is made to stimulate the more frequent use of fundus oculi examinations by internists in their routine practice, particularly those interested in cardio-vasculo-renal disorders. The findings in the more common diseases are summarized and evaluated as to importance in diagnosis and prognosis of the general disorders.

Discussion by L. H. Redelings, M. D., San Diego; William P. Corr, M. D., Riverside.



II

GENERAL SURGERY SECTION*

JOHN HUNT SHEPARD, M. D., *Chairman*
Medico-Dental Building, San Jose

J. M. SCHMOELE, M. D., *Secretary*
1930 Wilshire Boulevard, Los Angeles

NELSON J. HOWARD, M. D., *Assistant Secretary*
2814 Lyon Street, San Francisco

First Meeting—Auditorium

Monday, May 3, 1:30 p. m.

21. *Pseudobiliary Dyskinesia*—Stanley H. Mentzer, M. D., 450 Sutter Street, San Francisco.

New problems in diagnosis have been raised by the diagnosis of biliary dyskinesia evolved from the early anatomical work of Oddi and the physiologic work of Ivy. The application of these studies to clinical medicine has brought new difficulties that need clarification.

Discussion by Harold Brunn, M. D., San Francisco; Donald C. Collins, M. D., Los Angeles.

22. *Postoperative Evisceration—An Analysis of Thirty-Four Cases with a Review of Recent Literature*—Arthur Bowen, M. D., 1930 Wilshire Boulevard, Los Angeles.

A study of thirty-four cases of eviscerations with remarks based on a review of over two hundred cases from recent literature, with the object of analyzing the mechanism of production; suggestions in the presentation and treatment; and a consideration of the intrinsic factors of catgut affecting absorption and tissue reaction.

Discussion by Charles T. Sturgeon, M. D., Los Angeles; H. H. Searls, M. D., San Francisco.

23. *Traumatic Rupture of the Spleen—Report of Twenty-Three Cases*—Edmund Butler, M. D., 490 Post Street, San Francisco.

The paper will be a discussion of: (1) Various types of injuries, as subcutaneous, penetrating, explosive, and indirect. (2) Complications: Secondary hemorrhage and infection. (3) Symptoms: Particularly pain and its variability. (4) Diagnosis: Very difficult in the presence of other injuries.

Discussion by Lee Cohn, M. D., San Francisco; Herbert Chapman, M. D., Stockton.

24. *Report of a Series of Traumatic Rupture of the Liver*—Herbert S. Mooney, M. D., 1930 Wilshire Boulevard, Los Angeles.

A statistical study of a series of sixty cases of traumatic injuries to the liver emphasizing the etiologic factors; the symptoms, physical findings; indications for surgery; operative findings; operative procedure; complications; and end-results.

Discussion by Harlan Shoemaker, M. D., Los Angeles; Howard W. Stephens, M. D., San Francisco.

25. *The Place of Partial Gastrectomy and Duodenectomy in the Surgery of Duodenal Ulcer*—Ernst Gehrels, M. D., 490 Post Street, San Francisco.

Among surgeons and internists there is increasing dissatisfaction with the results of gastro-enterotomy and pyloroplasty. The late results of partial gastrectomy and duodenectomy are much better. In the experience of the author the mortality of

* Monitors: D. D. McKinnon, M. D., Los Angeles, and C. S. Stone, M. D., Santa Barbara.

partial gastrectomy and duodenectomy for ulcer is small. The indications for the radical operation should be very strictly drawn, and are given in detail.

Discussion by Emile Holman, M. D., San Francisco; J. Homer Woolsey, M. D., Woodland.

26. *Posterior Vaginal Hernia*—Ray B. McCarty, M. D., The Mission Inn Rotonda, Riverside.

Posterior vaginal hernia is a surgical oddity which has frequently been mistaken for rectocele, with resultant recurrence following surgery. A case report will be presented with a discussion of the subject, particularly from the standpoint of etiology, diagnosis, and treatment.

Discussion by Clarence G. Toland, M. D., Los Angeles; Bon O. Adams, M. D., Riverside.



Second Meeting—Auditorium

Tuesday, May 4, 8:30 a. m.

27. *Chairman's Address: Looking Forward*—John Hunt Shephard, M. D., Medico-Dental Building, San Jose.

28. *Prevention of Lymphedema of the Arm Following Radical Operation for Breast Cancer*—Alson R. Kilgore, 490 Post Street, San Francisco.

Causes of lymphedema: (1) Operative removal of main lymph trunks, (2) less than average collateral bed, or (3) destruction of collateral bed by lymphangitis.

Means of avoiding the last-named cause: (1) Incision so planned that fat-necrosis in healing will not occur in the collateral bed. (2) Technical operative procedures to avoid lymphangitis in this bed.

Outline of plan of operation.

Discussion by Orville N. Meland, M. D., Los Angeles.

29. *Experimental and Clinical Studies on Repair of the Dura Mater*—Mark A. Glaser, M. D., 727 West Seventh Street, Los Angeles; C. H. Thienes, M. D., Ph. D., School of Medicine, University of Southern California, Los Angeles. (By invitation.)

A series of twenty dogs have been studied for the purpose of determining the rapidity of dural repair with and without grafts; the type of cells which go to form new dura have been studied.

Grafts of animal membrane and fascia have been introduced and a comparison of the repair of all these have been carried out.

A clinical study of dural repair in tumors and depressed fractures will be reported to supplement these animal experiments.

Discussion by Howard Naffziger, M. D., San Francisco; James B. McNaught, M. D., Stanford University School of Medicine.

30. *Surgery in the Diabetic—A Ten-Year Survey*—Irving Wills, M. D., 1421 State Street, Santa Barbara.

This presentation outlines the management of a group of surgical diabetic patients seen during a ten-year period. It includes the dietetic regimen used by the author with a discussion of acidosis and peripheral circulatory collapse. Illustrative case reports are detailed.

Discussion by Gerald H. Beck, M. D., Glendale; Emile Holman, M. D., San Francisco.

31. *Subcutaneous Glomus Tumor*—L. R. Chandler, M. D., Stanford University Hospital, San Francisco.

Glomus tumor is a clinical entity presenting definite signs and symptoms. These consist primarily of pain of a peculiar type, resulting from pressure on a small pigmented tumor of the skin. Glomus tumors usually are in the extremities and most often under or near the nails. The typical history and physical findings are illustrated by a case report, which is accompanied by the pathologic findings.

Discussion by David A. Wood, M. D., San Francisco.

32. *Chronic Duodenal Stasis: A Syndrome with Neurologic Symptoms*—Frederick L. Reichert, M. D., Lane Hospital, San Francisco.

Chronic duodenal stasis is mentioned very briefly in textbooks of surgery. In the past decade several excellent articles have called attention to the symptoms, signs, and treatment of this condition. One of the common etiologic factors has been compression of the third portion of the duodenum by the superior mesenteric vessels. Symptoms of headache, vertigo, and vomiting have been sufficiently misleading as to suggest some neurologic disturbance. Illustrative case histories are presented briefly.

Discussion by Nelson J. Howard, M. D., San Francisco; John Homer Woolsey, Woodland.

RECESS

Business meeting and election of officers.



Third Meeting—Auditorium

Wednesday, May 5, 8:30 a. m.

33. *Parathyroid Adenoma*—William W. Washburn, M. D., 384 Post Street, San Francisco.

A case of hyperparathyroidism associated with osteofibrosis cystica and nephrolithiasis is presented. The clinical aspects, blood chemistry, bone and kidney changes are discussed. The anatomy of the parathyroids, indications for surgery and technical steps of the operation are outlined. The article is supplemented by photographs, photomicrographs and roentgenograms, and is followed by a bibliography.

Discussion by Hans Lisser, M. D., San Francisco; Robertson Ward, M. D., San Francisco.

34. *Inflammatory Strictures of the Rectum Associated with Lymphogranuloma Inguinalis*—Carleton Matthewson, Jr., M. D., Mattei Building, Fresno.

A historical, clinical, and pathologic study of the rectal lesions associated with lymphogranuloma inguinale is presented, with particular consideration of the early manifestations of the disease, the mode of infection, and treatment. (Lantern slides.)

Discussion by Robert A. Scarborough, M. D., San Francisco; Arthur Haim, M. D., San Francisco.

35. *The Nature and Treatment of Acute Ischio-rectal Abscesses*—Paul C. Blaisdell, M. D., 102 North Madison, Pasadena.

An analysis of a hundred cases of acute ischio-rectal abscesses and chronic fistulas reveals a common misunderstanding of the nature of the former, and their relation to the latter. Because they are called "abscesses," spontaneous acute ischio-rectal abscesses are too often regarded in nature, and treated as common abscesses elsewhere, with regrettable results.

Discussion by William H. Daniel, M. D., Los Angeles; A. J. Murrieta, M. D., Los Angeles.

36. *Acute Intestinal Obstruction*—J. Norman O'Neill, M. D., 1930 Wilshire Boulevard, Los Angeles.

An analysis of two hundred and fifty cases treated in the Los Angeles County General Hospital over a five-year period: Morbidity, mortality, signs and symptoms, early diagnosis, importance of exploratory laparotomy, x-ray, blood chemistry, leukocytosis, types of obstruction, etiology, age incidence, treatment, prophylactic, preoperative, postoperative, merits of ileostomy, Wetzel tube, Holden's method, resection, enterotomy, morphin, Levine suction, misleading factors, Hartman's solution, hypertonic and normal saline, pituitrin and enemas, pitressin.

Discussion by E. Vincent Askey, M. D., Los Angeles; Edward C. Palette, M. D., Los Angeles.

37. *Nonspecific Enteritis*—Charles S. Roller, M. D., Woodland.

Summary of newer knowledge since 1934 of this disease entity, with complete studies and observations of three proved cases. Diagnosis, variable appearance as seen at time of surgery, theories as to cause, treatment advised and subsequent clinical courses over a period of years. (Lantern slides.)

Discussion by Frederick Reichert, M. D., San Francisco; H. Glenn Bell, M. D., San Francisco.

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Fourth Meeting—Auditorium

Wednesday, May 5, 1:30 p. m.

SYMPOSIUM ON LOBAR PNEUMONIA

This will be a joint meeting of the following sections: Medicine; Surgery; Obstetrics and Gynecology; Pediatrics; Pathology; Eye, Ear, Nose, and Throat; and Radiology.

The program of this joint meeting is printed under the fourth meeting of the General Medicine Section. (See page 20.)

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Fifth Meeting—Auditorium

Thursday, May 6, 8:30 a. m.

38. *Reconstruction of the Enlarged Breast*—H. O. Barnes, M. D., 727 West Seventh Street, Los Angeles.

The technique of reconstructing the benign enlarged breast is given in word and by simultaneous running of Kodachroma film. Preoperative design and delineation, as well as postoperative result, are presented for evaluation and discussion.

Discussion by Eric Larson, M. D., Los Angeles; William Olds, M. D., Los Angeles.

39. *Branchial Cysts*—E. Eric Larson, M. D., 1930 Wilshire Boulevard, Los Angeles.

Author's paper based on fifteen patients with branchial cysts. The embryologic origin, signs and symptoms, as well as surgical care, will be discussed. (Motion pictures.)

Discussion by Arthur E. Smith, M. D., Los Angeles; J. Homer Woolsey, M. D., Woodland.

40. *Surgery of the Cleft Palate*—Arthur E. Smith, M. D., 1930 Wilshire Boulevard, Los Angeles.

Motion pictures.

Discussion by E. Eric Larson, M. D., Los Angeles; Gerald B. O'Conner, M. D., San Francisco.

41. *Recent Advances in the Surgical Treatment of Pulmonary Tuberculosis Through Selective Collapse by Partial Thoracoplasty*—Emile Holman, M. D., Stanford University Hospital, San Francisco.

Complete unilateral thoracoplasty is being supplanted by partial operations which endeavor to collapse only the affected lung. This obviates needless sacrifice of good lung, and prevents unnecessary reduction in vital capacity. The operative procedures being utilized are complete removal of first, second and third ribs, partial removal of additional ribs as indicated, removal of transverse processes, and partial resection of scapula in selected cases.

Discussion by Philip Pierson, San Francisco; Hans Schiffbauer, Los Angeles.

42. *The Use of Autogenous Strips of Fascia Lata in the Repair of the More Difficult Abdominal Hernias*—Donald C. Collins, M. D., 1930 Wilshire Boulevard, Los Angeles.

The development of the use of autogenous fascia lata sutures in hernioplasties is reviewed and important contributions are mentioned. The technique is outlined. A series of forty-four cases treated by this method are reported. There were no deaths. One case had a slight questionable recurrence.

Discussion by Hall G. Holder, M. D., San Diego; C. Latimer Callander, M. D., San Francisco.

III

**OBSTETRICS AND GYNECOLOGY
SECTION***

DONALD G. TOLLEFSON, M. D., *Chairman*
511 South Bonnie Brae, Los Angeles

R. GLENN CRAIG, M. D., *Vice-Chairman*
490 Post Street, San Francisco

GEORGE W. COON, M. D., *Secretary*
3770 Twelfth Street, Riverside

First Meeting—Copper Cup Room

Monday, May 3, 1:30 p. m.

43. *Episiotomy*—George D. Huff, M. D., 806 Medico-Dental Building, San Diego.

The mediolateral episiotomy is most commonly used. Novocain solution (one-half per cent) is injected along the line of incision, and the tissues are then carefully divided, layer by layer, with a sharp scalpel. After delivery, the wound is closed, layer by layer, with chromic catgut. Subcuticular stitches are used for the skin.

Discussion by A. M. McCausland, M. D., Los Angeles; Hall G. Holder, M. D., San Diego.

44. *Postpartum Hemorrhage*—Clarence A. De Puy, M. D., 230 Grand Avenue, Oakland.

In the study of maternal mortality, hemorrhage ranks second as a cause of death in the last trimester of pregnancy. This paper deals with preventive and curative measures, which, if adopted, will lessen our maternal mortality. It offers some suggestions to the health department that proper inspection be made of all maternities before permits are issued.

Discussion by Thomas Wier, M. D., San Diego; L. A. Emge, M. D., San Francisco.

45. *Roentgen-ray Pelvimetry: A Study of Three Hundred and Twenty Labors*—C. T. Hayden, M. D., University of California, San Francisco. (By invitation.)

In a series of 410 unselected cases which have been studied by the Caldwell and Moloy classification (using the Thoms plate for mensuration of the superior strait). It was found in our material at the University of California Hospital that 75 per cent of the pelves were of pure type, and 25 per cent mixed. Of this group, 320 primiparous labors were evaluated as to type of pelvis, duration of labor, size of baby and obstetrical index as a means of comparison.

It is apparent that, regardless of the type of pelvis, the character of the pains was most important from the standpoint of nonsurgical intervention in labor.

Discussion by A. V. Pettit, M. D., San Francisco; E. J. Krahulik, M. D., Los Angeles.

46. *The Relation of Hormones to Tumor Growth*—L. A. Emge, M. D., Stanford University School of Medicine, San Francisco.

After a brief review of the present status of the cancer problem, some of the newer theories about malignant behavior of cells are discussed. The relation of endocrine changes to tumor growth in man is analyzed and compared with the results of extensive laboratory research attempting to link carcinogenesis and tumor growth with endocrine dysfunctions. The estrogenic factor is discussed in detail and supplemented by personal experimental studies. (Lantern slides.)

Discussion by E. M. Hall, M. D., Los Angeles; Chauncey D. Leake, Ph. D., San Francisco. (By invitation.)

47. *Birth Injuries to the Bladder and Bowel: Their Management*—Norman F. Miller, M. D., University of Michigan Medical School, Ann Arbor, Michigan. (By invitation.)

* Monitors: R. W. Dunn, M. D., San Francisco, and George Huff M. D., San Diego.

Serious birth trauma to bladder and bowel has undoubtedly decreased with insistent demand for better obstetrics and resultant improved care. Even so, the mental and physical suffering from certain injuries to these organs warrants increasing effort toward their prevention and correction. This discussion is confined to the cause and cure of vesico-vaginal fistulae and complete perineal tears.



**Second Meeting—Copper Cup Room
Wednesday, May 5, 8:30 a. m.**

48. *The Cervix After Hysterectomy*—Erle Henriksen, M. D., Pacific Mutual Building, Los Angeles.

Six thousand five hundred and fifty cervical stumps examined clinically and pathologically. Four-tenths per cent developed cancer, 2.5 per cent returned for further treatment of benign lesions. Dilatation and curettage of canal indicated in examination of stump. Clinical symptoms arising from the stump are multiple. No indication for routine total hysterectomy. Microscopic examination of material obtained under direct vision important.

Discussion by Henry N. Shaw, M. D., Los Angeles; R. Glenn Craig, M. D., San Francisco.

49. *Progress in Maternal and Child Welfare Under the Social Security Act and Their Relation to Obstetrics*—Lyle G. McNeile, M. D., 3780 Wilshire Boulevard, Los Angeles.

The meeting of the Advisory Committee of the Children's Bureau will not be held until April 8, 1937. The meeting is to be held in Washington, and it will be absolutely impossible to obtain an adequate picture of the situation in so far as the relation of the medical profession to Title III of the Social Security Act is concerned until after this meeting. The meeting is to be attended by fifteen or twenty of the leading obstetricians and will afford an opportunity to obtain a fairly accurate idea of what is going on over the entire United States.

Discussion by Frank Lynch, M. D., San Francisco; Karl Schaupp, M. D., San Francisco.

50. *Chairman's Address: Hospital Consultation in Private Obstetrics*—Donald G. Tollefson, M. D., 511 South Bonnie Brae, Los Angeles.
51. *Radium Reaction in Cancer of the Cervix*—Frank Lynch, M. D., University of California Medical School, San Francisco.

A histologic study of uteri removed after radiation of cancer of the cervix. Has given findings of interest in the study of radiation. A paper presenting fifteen such uteri radiated by various methods in general usage, and showing the inadequacy of most of them. The study will be presented from lantern slides.

Discussion by L. A. Emge, M. D., San Francisco; Lyle G. McNeile, M. D., Los Angeles.

52. *Skin and Chemical Tests for Pregnancy*—R. D. Dunn, M. D., 2000 Van Ness Avenue, San Francisco; Paul E. Hoffmann, M. D., 2286 Jackson Street, San Francisco, and Florence L. Fouch, M. D., 490 Post Street, San Francisco.

The experience with chemical and skin tests for pregnancy in seven hundred patients is reviewed. The technique of these tests and certain modifications are discussed.

The study includes observations made in relation to normal and abnormal pregnancy, abortions, and nonpregnant conditions. Simplicity in technique make these tests attractive, but the end-results indicate that their reliability, as compared with biologic tests, is still uncertain.

Discussion by D. G. Morton, M. D., San Francisco.

RECESS

Business meeting and election of officers.

**Third Meeting—Auditorium
Wednesday, May 5, 1:30 p. m.**

SYMPOSIUM ON LOBAR PNEUMONIA

This will be a joint meeting of the following sections: Medicine; Surgery; Obstetrics and Gynecology; Pediatrics; Pathology; Eye, Ear, Nose, and Throat; and Radiology.

The program of this joint meeting is printed under the fourth meeting of the General Medicine Section. (See page 20.)



IV

EYE, EAR, NOSE, AND THROAT SECTION*

DEAN E. GODWIN, M. D., *Chairman*
820 Professional Building, Long Beach

CLIFFORD WALKER, M. D., *Vice-Chairman*
427 West Fifth Street, Los Angeles

FRANK BAXTER, M. D., *Secretary*
1624 Franklin Street, Oakland

**First Meeting—Copper Cup Room
Tuesday, May 4, 8:30 a. m.**

53. *Pulmonary Injury Caused by Intratracheal Instillation of Liquid Petrolatum*—George H. Houck, M. D., 2007 Wilshire Boulevard, Los Angeles.

An illness which followed therapeutic intratracheal instillation of liquid petrolatum and which resembled the so-called lipid pneumonia is described. The patient lived for six years and eight months, during which period oil globules were frequently found in the sputum. Serial roentgenograms made throughout this long illness showed at first a fine granular mottling over the lower lung fields. Later the left lower, right lower, and middle lobes were seen to shrink slowly and were finally represented by small, round, dense shadows, just above the diaphragm. During the same period both upper lobes of the lungs became abnormally translucent and the physical signs of emphysema appeared. At necropsy the characteristic picture of an oil foreign body was found, together with extensive and long-standing fibrotic changes. A quantity of this oil was removed and identified as mineral oil.

Discussion by George McClure, M. D., Oakland.

54. *A Planned, Complete Tonsillectomy*—William Remfrey Hunt, M. D., 1525 State Street, Santa Barbara.

Discussion is made of a planned, complete removal of the palatine tonsil and its lymphoid appendages. Slides of seven consecutively removed tonsils with appendages attached are shown. A dissection and snare method with an anatomical approach is used. The plica triangularis is routinely incised from the margin of the anterior pillar at the onset. Careful dissection under direct vision with good lighting frees the upper pole, the posterior and anterior pillars completely. When snaring, the tenaculum includes the lower pole, the tongue depressor is removed, allowing the lateral lingual and subtonsillar tissue to rise into the snare, which is forced downward. While this often completes the removal, a thorough inspection with the tongue depressor, pillar retractor, and Allis forceps is made. This may reveal extracapsular lymphoid masses at the upper pole, behind the anterior pillar, or on the extreme lower lateral surface of the tongue. These are removed with the Allis or Allis and snare. Any other methods accomplishing similar results are approved.

Discussion by Herman Semenov, M. D., Los Angeles.

* Monitor: Clifford B. Walker, M. D., Los Angeles.

55. *Infection in the Danger Area of the Lips, Face, and Nose*—G. W. Walker, M. D., 2014 Tulare Street, Fresno; Hugh Awtrey, M. D., 532 Patterson Building, Fresno. (By invitation.)

In the literature of the subject of infections in the danger area of the lips, face, and nose, there is caution about injuring the tissues by picking, squeezing, or even wide cutting through the diseased area into the healthy tissues either laterally or deeply. With all of this we agree. All agree to careful expectant treatment as for patient gravely sick. Many advise no surgical treatment should be used at all. About all the others advise operation only on the grave cases. We urge gentle handling, but evacuation of pus wherever pus forms, sterilizing all cuts with pure phenol followed in two minutes by alcohol to stop the action of the phenol. If the pustule be small it is most simple; if threatening, it is promptly stopped. Large carbuncles should be cautiously entered, septa broken and made into one or fewer cavities to arrest diseased process. Further venous involvement will not then take place. Such treatment is effective. Watchful waiting allows deaths from cavernous sinus thrombosis, meningitis, and septicemia.

Discussion by George F. Keiper, M. D., Los Angeles.

56. *Irrigation of the Maxillary Sinuses Through the Ostium—Moving Pictures of Technique, with Anatomical Demonstration*—Charles E. Futch, M. D., 1930 Wilshire Boulevard, Los Angeles.

Irrigation of the maxillary sinus is an established diagnostic and therapeutic procedure in the usual practice of rhinology. The less trauma inflicted upon the nasal mucosae in treatment the more rapidly the tissues approach the normal state, and the patient will suffer comparatively little discomfort. Irrigation through the ostium is not new or unusual, but a simple demonstration of the technique may stimulate even a wider use of this method. The approach to the antrum through the ostium or accessory ostia is not always applicable. There are indications, contra-indications, advantages, and disadvantages. The anatomical accessibility makes this method impossible in some cases, and it is well to recognize these exceptions rather than force cannulization. The modified instruments and technique of procedure are shown in motion pictures, both upon the cadaver and patient. Complications and end-results are presented with a summary for the consideration of the assembled Society.

Discussion by J. Randolph Sharpsteen, M. D., Oakland.

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Second Meeting—Art Gallery Wednesday, May 5, 8:30 a. m.

57. *Ear Manifestations Following Head Injuries*—Frank Hand, M. D., 490 Post Street, San Francisco.

The most common ear symptoms encountered following severe head injuries are a loss of hearing or decrease in hearing for high tones. The next symptom in order of frequency is hyperirritability of the labyrinth, which is manifested by dizziness and aggravated by quick head movements. Ear symptoms are usually found following severe concussions of the brain with or without skull fracture and irrespective of whether or not the fracture extends through the petrous portion of the temporal bone. Following severe concussions of the brain with or without fracture, patients suffer from hyperirritability of the labyrinth, which is characterized by dizziness and a diminution of hearing for high tones. These patients, if insurance cases, must be given a permanent disability because the symptoms will not improve and we have no satisfactory treatment for this condition. The longitudinal fracture through the petrous portion of the temporal bone is the typical middle ear fracture, and is usually characterized by bleeding from the

ear and progressive loss of hearing for low tones. A crossing fracture through the petrous portion of the temporal bone will leave the patient totally deaf in the affected ear if he recovers.

Discussion by Harold A. Fletcher, M. D., San Francisco.

58. *Ionization in Allergic Rhinitis*—H. James Hara, M. D., 432 South Boyle Avenue, Los Angeles.

Ionic medication has fascinated the medical profession for more than a century. When a weak solution of sulphate of zinc is used as electrolyte it coagulates the superficial epithelium of the nasal mucosa. Discussion of various operative techniques, armamentaria, indications and contra-indications in allergic rhinitis is given. Review of one hundred consecutive cases from the author's private and dispensary cases is presented. Slides are shown, demonstrating the reaction of the nasal mucosa at various periods during and following ionization.

Discussion by G. W. Walker, M. D., Fresno.

RECESS

Business meeting and election of officers.

59. *The Use of Snake Venom in Postoperative Hemorrhage of the Eye*—Wilber F. Swett, M. D., 490 Post Street, San Francisco.

During the past six months I have had several stubborn postoperative hemorrhage cases which failed to respond to the usual procedures. The continuous oozing of blood from the iris into the anterior chamber following cataract extraction prolongs the healing and in many instances results in the failure of the wound to close, or even a painful eye with rupture of the wound and prolongs seepage from the anterior chamber. In the first case, hemorrhage occurred the first day after operation and continued to ooze in spite of all treatment for ten days. In search of some more radical means of stopping this hemorrhage, I decided to try Moccasin Venom, put out by Lederle. I was very pleasantly surprised when the oozing immediately stopped after the injection of 0.4 cubic centimeter. The blood disappeared rapidly from the anterior chamber, the wound healed, and the man was discharged four days later. I have used it in three cases since with identical results. I believe Moccasin Venom has a very definite place as a prophylactic procedure in all intra-ocular surgery.

Discussion by Warren D. Horner, M. D., San Francisco.

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Third Meeting—Auditorium Wednesday, May 5, 1:30 p. m.

SYMPOSIUM ON LOBAR PNEUMONIA

This will be a joint meeting of the following sections: Medicine; Surgery; Obstetrics and Gynecology; Pediatrics; Pathology; Eye, Ear, Nose, and Throat; and Radiology.

The program of this joint meeting is printed under the fourth meeting of the General Medicine Section. (See page 20.)

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Fourth Meeting—Art Gallery Thursday, May 6, 8:30 a. m.

60. *The Usefulness of the Detailed Diet History in the Practice of Ophthalmology and Otolaryngology*—Ray M. Moose, M. D., 3170 Valencia Street, San Bernardino.

There are various types of cases for which the detailed diet history is useful not only in treatment but in diagnosis and prognosis and in study of etiology, hence increased efficiency with its aid. Chart of returns of questionnaire on extent diet history is used by California specialists. Evaluation of data obtained on a detailed diet history form.

Discussion by Eugene R. Lewis, M. D., Los Angeles.

61. *Microsurgery in Glaucoma*—Otto Barkan, M. D., 490 Post Street, San Francisco.

The writer has recently reported an operation which consists of opening Schlemm's canal under direct magnified vision for the relief of chronic simple glaucoma. Its effect is to remove the block to the circulation of intra-ocular fluid which is the mechanical cause for the increased intra-ocular pressure. It restores the physiologic direction of outflow to the intra-ocular fluid. By means of a surgical contact glass, under which the operation is performed, the surgeon can see the area of blockage and can watch and guide his instrument during the operation. Occasionally, when Schlemm's canal has been insufficiently opened the intra-ocular pressure is only partially reduced. In these cases the use of miotics or further operation at a later date secures normalization of pressure. In the present article a technical improvement is suggested which facilitates the operation on Schlemm's canal. It consists of increasing the magnification from 4 x, as used heretofore, to 20 x. This magnification is obtained by using the binocular corneal microscope attached to the surgeon's head by means of a helmet. This would seem to secure the proper striking and opening of Schlemm's canal in those cases where it is indicated.

Discussion by A. R. Irvine, M. D., Los Angeles.

62. *Abnormal Retinal Correspondence*—K. C. Brandenburg, M. D., 110 Pine Avenue, Long Beach.

Attention is called to a neglected aspect of the problem of strabismus, which must be considered when operation or orthoptic training is contemplated. Since abnormal retinal correspondence is present in about 50 per cent of all squint cases and must be corrected as a preliminary to successful or orthoptic training, its recognition, and treatment are a matter of interest and importance. The recurrence of a deviation following operation may be due to an attempted reestablishment of this old defective sensorial relationship, especially in cases where there is a small angle of deviation and the visual acuity is good in both eyes. Ordinary methods of orthoptic training in cases showing abnormal retinal correspondence results in failure to influence the deviation and serve only to fix the anomaly, doing more harm than good. Methods of diagnosis and treatment of this condition are described.

Discussion by John Lordan, M. D., Los Angeles.

63. *Critical Decisions in Cataract Surgery*—Harold F. Whalman, M. D., 1148 Roosevelt Building, Los Angeles.

A presentation of opinions regarding the opportune time to operate congenital cataract, unilateral cataract, complicated cataract, traumatic cataract, and dinitrophenol cataract. Controversial points are considered. The subject is presented with a view to encourage discussion and criticism.

Discussion by K. C. Brandenburg, M. D., Long Beach; Dohrmann Pischel, M. D., San Francisco.

64. *A New Surgical Procedure for the Correction of Spastic Entropion*—Alfred R. Robbins, M. D., 1930 Wilshire Boulevard, Los Angeles.

Many surgical procedures, varying from simple igni punctures to mutilating operations on the lower eyelid, have been advocated for the treatment of spastic entropion. None of them offer a permanent relief of the entropion, and recurrences are common in obstinate cases. An effective and simple solution of the problem has been recently proposed by Poulard. Following an ordinary canthectomy, the muscle and connective tissue fibers, responsible for excessive traction upon the upper border of the tarsal plate, are severed by means of a deep incision. The latter is carried out perpendicularly to the course of the fibers. In closing the wound, the modification by Pochisow seems to offer a better cosmetic result.

Discussion by Julian M. Dow, M. D., Los Angeles.

V

ANESTHESIOLOGY SECTION*

HARRY J. SMITH, M. D., *Chairman*
3115 Webster Street, Oakland

WILLIAM LEROY GARTH, M. D., *Secretary*
233 A Street, San Diego

First Meeting—Private Dining Room
Wednesday, May 5, 8:30 a. m.

65. *Chairman's Address: Pertinent Comments on Anesthesia*—Harry J. Smith, M. D., 3115 Webster Street, Oakland.
66. *Recent Studies of Local Anesthesia*—M. L. Tainter, M. D., Stanford University Medical School, San Francisco (by invitation); A. H. Thronson, D.D.S., College of Physicians and Surgeons, San Francisco (by invitation), and S. M. Moose, D.D.S., College of Physicians and Surgeons, San Francisco (by invitation).

Over two thousand observations were made of the power of various drugs to anesthetize the oral mucosae by surface application. Blank control solutions were tested simultaneously to rule out factors of suggestion and technical errors. The drugs studied, in order of increasing efficiency, were: tuto-cain, metycain, procain, cocain, diothane, phenol in water, pantocain, nupercain, butesin, butyn, laro-cain, benzyl alcohol, orthoform, "butyn topical solution," saligenin, benzocain, menthol, chlorbutanol, and phenol in alcohol. Some of the most effective were not clinically usable because they caused tissue necrosis. The alkaline procain borate (boracain) solution was tested as an injection anesthetic against the acid procain hydrochlorid. Although the differences were small, the borate solution produced less damage in the tissues, but more systemic reactions than the hydrochlorid solutions. The three commonly available vasoconstrictors—epinephrin, cobe-frin, and neosynephrin—were also compared in these anesthetic solutions. The results show points of advantage and disadvantage for each.

67. *The Explosion Hazard in Anesthetic Gas Mixtures*—Clarence G. Toland, M. D., 1930 Wilshire Boulevard, Los Angeles.

The advantage of the closed system of administering inhalation anesthetics, using mixtures of cyclopropane-oxygen, nitrous oxid-oxygen, and ethylene-oxygen, with or without ether, is discussed. The risk of explosion is considered and the literature reviewed. Suggestions are given for the diminution of the explosive hazard.

68. *Regional Anesthesia for Orthopedic Operations*—Charles F. McCuskey, M. D., 3435 Amesbury Road, Los Angeles.

The use of regional anesthesia for time-consuming orthopedic operations frequently offers the patient greater safety and comfort during and after the surgical procedure than can be obtained with general anesthesia. The technique for cervical, brachial, and paravertebral block is described.



Second Meeting—Copper Cup Room
Wednesday, May 5, 1:30 p. m.

69. *Spinal Anesthesia—Present Status*—Louis H. Maxson, M. D., 1424 Fourth Avenue, Seattle, Washington. (By invitation.)

Spinal anesthesia now established. Substantial agreement on principles. The problem of spinal anesthesia. Intraspinal action of anesthetic governed by fixed laws. No rapid mass movements. Dispersion, convection, diffusion. Ways of controlling height. Safety margin, "brake action," safety

* Monitors: Hal Kelly, M. D., San Diego, and John Dunlop, M. D., Los Angeles.

factor. Limitation of the method; diminished mortality. Sequelae. Pontocain; nupercain. Supplementary anesthesia.

70. *Compensatory Pressure in Anesthesia for Thoracic Surgery*—W. Lawrence, M. D., 54 Brentwood Avenue, San Francisco.

(1) A brief review of normal intrathoracic pressures. (2) The physics and anatomy of disturbed intrathoracic pressures during surgery. (3) Compensatory pressure and an analysis of its operation. (4) Observations regarding anesthetic agents in relation to this subject.

Discussion by G. D. Delprat, M. D., 384 Post Street, San Francisco.

71. *Avertin Anesthesia*—Dorothy A. Wood, M. D., 1390 Seventh Avenue, San Francisco.

An appreciation of the use of this drug in the preoperative preparation of the patient, based on seven years' experience. Dosage: Combination of tribromethanol with local anesthesia, ether anesthesia, and nitrous oxid and oxygen anesthesia.

72. *Systemic Adrenalin Reaction in Local Anesthesia*—Karolina B. Jump, M. D., Mills Memorial Hospital, San Mateo.

The use of adrenalin in local anesthesia—its method of administration and its effects in normal individuals; unfavorable reactions from its use; conditions under which reactions may not be expected; contra-indications for its administration and experimental evidence for its physiologic effects. Suggestions for the prevention and treatment of unfavorable adrenalin reactions.

73. *American Society of Anesthetists, Incorporated: Its Aims and Accomplishments*—W. W. Hutchison, M. D., 1930 Wilshire Boulevard, Los Angeles.

A history of the organization from the founding of the parent society in 1905. The accomplishments of the organization in the advancement of ethical medicine and particularly the specialty of anesthesia during its existence.

The future objectives of the society to advance anesthesia throughout the medical profession, beginning with adequate instruction in medical schools, in an endeavor to attract capable men to the specialty. And, finally, the certification of recognized specialists under the National Board of Certification.

RECESS

Business meeting and election of officers.



VI

DERMATOLOGY AND SYPHILOLOGY SECTION*

THOMAS J. CLARK, M. D., *Chairman*
400 Twenty-Ninth Street, Oakland

PHILIP K. ALLEN, M. D., *Vice-Chairman*
Medico-Dental Building, San Diego

GEORGE V. KULCHAR, M. D., *Secretary*
450 Sutter Street, San Francisco

First Meeting—Directors' Room
Monday, May 3, 1:30 p. m.

74. *Chairman's Address: The Education of a Dermatologist*—Thomas J. Clark, M. D., 400 Twenty-Ninth Street, Oakland.

A dermatologist is a well-trained physician who is fitted, by special preparation, to comprehend the skin and its ills as an organ of the body.

There are three phases to this preparation period: the academic, the medical, and the postgraduate dermatologic training. The time values for these periods should be four years in the academic

branches, receiving general education; then follows basic medical education, which should occupy four years. At the conclusion of a year's hospital work as an intern, the student has his literary or science degree and the M. D. degree.

Four years of general medical practice, followed by a year's postgraduate work in dermatology, prepares the student for a successful career at thirty years of age, and with high capacity.

75. *Drug Eruptions Due to the Barbiturates*—Frederick G. Novy, Jr., M. D., 411 Thirtieth Street, Oakland.

This paper will discuss the various types of cutaneous manifestations seen following the use of the different barbiturates. Special reference will be made to the fixed eruption which can be caused by this group. A case will be reported in which this type of eruption was found to be due to sodium amytal.

Discussion by Stanley O. Chambers, M. D., Los Angeles.

76. *Rhinoscleroma in California*—Harry E. Alderson, M. D., 490 Post Street, San Francisco.

The symptomatology, pathology, and epidemiology are discussed. Three additional cases occurring in California are reported. In some, lesions occurred only in the mouth and nasopharynx without external evidence of the disease. It is probable that more cases exist in California among the Mexicans and Central Americans, in whose countries the disease is quite prevalent. Treatment is discussed.

Discussion by Rea Ashley, M. D., San Francisco; Arne E. Ingels, M. D., San Francisco; Samuel Ayres, Jr., M. D., Los Angeles; Otto P. Diederich, M. D., Fresno.

77. *Endocrine Therapy in Acne*—Harry J. Templeton, M. D., 3115 Webster Street, Oakland, and Stanley R. Truman, M. D., 1904 Franklin Street, Oakland.

Because of its onset at puberty, its frequent exacerbation at menstrual periods and its disappearance during the postpuberty period, it is felt by the authors that acne vulgaris is intimately associated with certain as yet unknown endocrine influences. Several writers have reported good results from treating acne by means of various glandular extracts.

We have treated one series of students with amniotin and another series with antuitrin S. Report of results. Photographs. Our results were rather poor in each series although some students were benefited. In spite of our poor results, we feel that this field is worthy of further study.

Discussion by Laurence Taussig, M. D., San Francisco.

78. *The Clinical Management of Cutaneous Malignancy*—Eric Liljencrantz, M. D., 2361 Clay Street, San Francisco, and George V. Kulchar, M. D., 450 Sutter Street, San Francisco.

A review of available material has revealed many instances in which cutaneous malignancy has been mismanaged. The reasons include inaccurate clinical diagnosis and inadequate treatment and follow-up.

An attempt is made to formulate a more rational approach to this important problem.

Discussion by Clyde K. Emery, M. D., Los Angeles; Harry J. Templeton, M. D., Oakland; David A. Wood, M. D., San Francisco.

79. *A New Spirochete Stain: Its Clinical Application in Primary Syphilis*—Stanley O. Chambers, M. D., 727 West Seventh Street, Los Angeles, and Julius R. Scholtz, M. D., 1930 Wilshire Boulevard, Los Angeles.

The percentage difference in the clinical and serologic care of early syphilis between the darkfield positive seronegative group and the seropositive is roughly 25 per cent. Early identification would, therefore, seem a great advantage; likewise, any method which would increase accuracy and simplicity in the identification of the early phase would seem a most welcome advance. This would be particularly true in the public health respect.

* Monitor: Herman V. Allington, M. D., Oakland.

A new spirochete stain has been utilized in primary lesions to identify the disease in its earliest manifestation. A comparison has been carefully made with the darkfield procedure and subsequent serologic or clinical changes.

Results would appear gratifying.

Discussion by Norman Epstein, M. D., San Francisco; Louis F. X. Wilhelm, M. D., Los Angeles.

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Second Meeting—Directors' Room

Tuesday, May 4, 8:30 a. m.

80. *Vitamin D in the Treatment of Acne Vulgaris*—Merlin T.-R. Maynard, M. D., Medico-Dental Building, San Jose.

A series of cases of acne are presented in which full doses of viosterol accompanied the standard treatment. These are compared with a similar group without viosterol. The survey covers five years of observation. Mention is made of observations of the use of viosterol in a few other conditions.

Discussion by George V. Kulchar, M. D., San Francisco; Harry J. Templeton, M. D., Oakland.

81. *Favus in California*—Norman N. Epstein, 450 Sutter Street, San Francisco, and Edward A. Levine, M. D., 450 Sutter Street, San Francisco.

Report of a case from California with a consideration of the clinical picture, the classification and types of organisms involved. The contagiousness, treatment and incidence of this disease in California and the United States are also considered.

Discussion by Hiram E. Miller, M. D., San Francisco; Nelson P. Anderson, M. D., Los Angeles.

82. *Grass Dermatitis (Dermatitis Bullosa Striata Pratensis)*—Saul S. Robinson, M. D., 1930 Wilshire Boulevard, Los Angeles.

Grass dermatitis or "dermatitis bullosa striata pratensis" has been described in Europe since 1926. No cases of the condition have been recorded heretofore in California. The patient is a female, age fifteen, who presents the typical pigmentary lesions of the disorder. A complete survey of the literature with a discussion on the etiology, differential diagnosis, and treatment of the condition is given. Photographs accompany the presentation.

Discussion by William H. Goeckerman, M. D., Los Angeles; Samuel Ayres, Jr., M. D., Los Angeles.

83. *The Plan for Combating Syphilis in California*—Howard Morrow, M. D., 384 Post Street, San Francisco.

Syphilis is a serious public health problem. It merits a well-developed campaign to decrease it to the lowest possible level. A number of plans have been developed, and the following will be discussed: (1) The Scandinavian plan; (2) The Massachusetts plan; (3) The New York plan; and (4) The plan of the California State Board of Health.

Discussion by William H. Goeckerman, M. D., Los Angeles.

84. *The Role of the Physician in the Control of Syphilis*—Charles W. Barnett, M. D., Stanford University, San Francisco.

The two factors of incidence and morbidity in determining the public health importance of a disease are pointed out. These are estimated for syphilis. The effectiveness of treatment in preventing transmission and late sequelae is demonstrated. In spite of the present lack of legal control, it is possible to greatly reduce the incidence of the disease and the damage produced by it if physicians would regularly give patients detailed information about the disease before treatment is started, and also if they would regularly attempt to bring under treatment sources of recent infections.

Discussion by George V. Kulchar, M. D., San Francisco.

85. *Vitiligo as a Manifestation of Possible Dysfunction of the Suprarenals Due to Congenital Syphilis*—Sophie A. Lurie, M. D., 610 South Broadway, Los Angeles.

Millian's idea of vitiligo as congenital syphilis manifestation induced us to use bismuth salicylate.

Dead chalky areas responding promptly, more noticeable on exposed parts of the body. Asthenic symptoms, metabolic changes associated with loss of pigment, speak for endocrine involvement, possibly suprarenals. Kinney's fundus' paravascular streakings as syphilis manifestations showed in our patients' eyes.

Discussion by Francis M. Pottenger, M. D., Los Angeles; Samuel Ayres, Jr., M. D., Los Angeles.

RECESS

Business meeting and election of officers.



VII

INDUSTRIAL MEDICINE AND SURGERY SECTION*

SAMUEL S. MATHEWS, M. D., *Chairman*
1913 Wilshire Boulevard
Los Angeles

H. G. McNEIL, M. D., *Secretary*
523 West Sixth Street
Los Angeles

First Meeting—Art Gallery
Tuesday, May 4, 8:30 a. m.

86. *Problems of Industrial Surgery*—Ross W. Harbaugh, M. D., 350 Post Street, San Francisco.

(a) A discussion of malignant tumors in relationship to trauma and decisions made before the Industrial Accident Commission.

(b) A discussion of silicosis, with reference to decisions before the Industrial Accident Commission.

Discussion by Arthur B. Fisher, M. D., San Francisco; E. B. Towne, M. D., San Francisco.

87. *Trauma and Malignancy*—Edwin I. Bartlett, M. D., 490 Post Street, San Francisco.

May trauma cause development of malignant growth?

May trauma cause a benign growth to become malignant?

May trauma stimulate a malignant growth to greater malignancy?

In a given case, what factors must be proved to establish a relationship?

In the doubtful or not positively proved instance, where does the responsibility lie?

Discussion by Zera E. Bolin, M. D., San Francisco; George D. Maner, M. D., Los Angeles.

88. *Pulmonary Manifestation of Coccidioidal Granuloma*—Frank Porter Miller, M. D., 523 West Sixth Street, Los Angeles.

The cases that came under this study were largely of an acute character and were characterized by a rapid migrating type of pneumonia with generalized septicemia and a fatal termination. From a medico-legal viewpoint they were most interesting, and the risk of communicability is a big factor in determining whether an award should be granted.

Discussion by Roy W. Hammack, M. D., Los Angeles; J. Mark Lacey, M. D., Los Angeles.

89. *The Relationship of Atmospheric Impurities to Industrial Problems*—Munford Smith, M. D., Barlow Sanatorium, Los Angeles.

This paper does not refer to pneumoconiosis. It owes its origin to the many cases seen by its author

*Monitors: John J. Loutzenheiser, M. D., San Francisco, and Richard B. McGoveny, M. D., Santa Barbara.

whose only justification for filing a compensation claim was the presence in the atmosphere of an odor.

It is an attempt to differentiate the imaginary from the real, the sentimental from the scientific.

Discussion by L. R. Chandler, M. D., San Francisco; William P. Shephard, M. D., San Francisco; John Ruddock, M. D., Los Angeles.



Second Meeting—Billiard Room

Wednesday, May 5, 8:30 a. m.

90. *Anomalies of the Spine: An Anatomical, Radiological, and Clinical Correlation*—Wilbur Bailey, M. D., 1212 Shatto Street, Los Angeles, and Ray A. Carter, M. D., General Hospital, Los Angeles.

Most anomalies of the spine have an origin of which the embryology is well understood. Correlation of the anatomical and radiological findings is, therefore, usually not difficult.

About the relationship of the radiological to the clinical findings, in some types of anomalies there is no general agreement. While certain anomalies, such as failure of fusion of the spinous process of the fifth lumbar vertebra (spina bifida), are universally considered as not producing symptoms, the discovery of other anomalies such as partial sacralization of the last lumbar vertebra is often taken as sufficient explanation for any symptoms which may be present.

Discussion by Richard F. Taylor, M. D., Los Angeles; John Saunders, M. D., San Francisco. (By invitation.)

91. *Newer Methods of Recognition and Treatment of Gas Bacillus Infection*—C. Latimer Callander, M. D., 450 Sutter Street, San Francisco, and Arthur Haim, M. D., 450 Sutter Street, San Francisco.

1. Definition, purpose, and reasons for interest in the subject.

2. Nomenclature and biological characteristics of gas bacilli.

3. History of gas gangrene.

4. Pathogenesis of disease.

5. Incidence of various anaerobes in gas gangrene in war wounds.

6. Pathology. (a) Essentially a disease of the muscles.

7. Treatment. (a) Prophylactic treatment other than serum; (b) Prophylactic serum; (c) Inspect wound frequently; (d) Early active treatment; (e) Late active treatment.

Discussion by Arthur Haim, M. D., San Francisco; F. C. Warnshuis, M. D., San Francisco; Thomas O. Burger, M. D., San Diego.

92. *What the Doctor Should Know About Law for His Own Protection*—William M. Rains, Attorney, 453 South Spring Street, Los Angeles. (By invitation.)

(a) The nature of the legal obligation imposed upon the doctor when the relationship of physician and patient begins.

(b) How long does that obligation continue?

(c) How may the doctor terminate the relationship of physician and patient and relieve himself of that obligation?

(d) What is malpractice?

(e) How is it proved in court? This includes a discussion of expert testimony, and conditions where expert testimony is not necessary.

(f) Fees for the expert witness.

(g) Responding to subpoenas.

(h) Cause for malpractice cases.

(i) Desirability of adequate records.

(j) Necessity for x-rays.

(k) The rule as to the Statute of Limitations and when a doctor should and should not bring his suit for fees.

(l) Some suggestions for keeping out of trouble.

Discussion by Harold Dewey Barnard, M. D., Los Angeles; Carl W. Rand, M. D., Los Angeles.

93. *Use Destruction in the Human Body*—A. W. Meyer, Department of Anatomy, Stanford University, Palo Alto. (By invitation.)

Lesions in the subcutaneous bursae. The articular capsules, ligaments, tendons, cartilages and sometimes even of the bones and muscles, up to complete local destruction and sometimes of dislocation, not attributable to any known pathologic process, will be discussed and demonstrated.

Discussion by Donald E. King, San Francisco; Vernon P. Thompson, M. D., Los Angeles.

RECESS

Business meeting and election of officers.



VIII

NEUROPSYCHIATRY SECTION*

J. M. NIELSEN, M. D., *Chairman*
727 West Seventh Street, Los Angeles

FRED O. BUTLER, M. D., *Secretary*
Sonoma State Home, Eldridge

First Meeting—Play Room

Monday, May 3, 1.30 p. m.

94. *Criminal Insane in a State Institution*—R. A. Cushman, M. D., Mendocino State Hospital, Talmage. This paper embodies the following:

1. Conflict between criminal laws and psychiatry.

2. The psychiatrist in criminal proceedings.

3. Suggested changes in laws governing trials of psychotic criminals.

Discussion by B. W. Black, M. D., Oakland; Glenn Myers, M. D., Los Angeles.

95. *Psychiatric Manifestations Ascribable to Focal Cerebral Lesions*—Samuel D. Ingham, M. D., 727 West Seventh Street, Los Angeles.

While the separation is not absolute between psychiatric and neurologic manifestations, there are, nevertheless, certain symptoms commonly considered psychiatric which relatively recently have been shown to be caused by focal cerebral lesions. Disorientation, hallucinations, and loss of power of recognition are examples of these. Cases are cited showing the value of these symptoms in neurologic diagnosis when caused by focal lesions.

Discussion by George S. Johnson, M. D., San Francisco; Walter F. Schaller, M. D., San Francisco.

96. *Is General Paresis Curable?*—Walter F. Schaller, M. D., 909 Hyde Street, San Francisco.

Survey of recent literature on treatment and prognosis. The clinico-pathological syndrome and diagnosis. Detailed record of personal cases observed over a considerable period following adequate treatment. Conclusions.

Discussion by George S. Johnson, M. D., San Francisco; Samuel Ingham, M. D., San Francisco.

97. *Development of the Idea of the Psychopathic Personality From Koch*—Edward W. Twitchell, M. D., 909 Hyde Street, San Francisco.

Especially from the time of Kraepelin to the present, the early years of the child, especially prior to the juvenile court period and the type of case which never comes into the juvenile court. The different types and the variety of problems presented. What can one do for the parents and families? Management of the child at home and in school. The adolescent period and its particular problems. The psychopathic personality in adult life with relation to his effect upon his family. Protection for the family and methods of arriving at it.

Discussion by Paul Gliebe, M. D., San Francisco.

* Monitors: George S. Johnson, M. D., San Francisco; C. W. Mack, M. D., Livermore.

Second Meeting—Play Room

Tuesday, May 4, 8:30 a. m.

98. *Migraine*—Henry Alsop Riley, A. M., M. D., Columbia University, New York. (By invitation.) In Children; Accepted and Questionable Types; Hypophyseal Theory and the Vascular Theory of Genesis; Pain in the Head; Radiology and Migraine; Treatment.

99. *Handwriting a Neurological Study*—H. Douglas Eaton, M. D., 1136 West Sixth Street, Los Angeles.

A brief discussion is presented of the mechanism of disorders of handwriting in neurologic conditions. The value of a study of handwriting as an aid in neurologic diagnosis is stressed and will be illustrated by a lantern-slide demonstration of types of handwriting with organic and functional neurologic diseases.

Discussion by Samuel Ingham, M. D., San Francisco; Walter F. Schaller, M. D., San Francisco.

100. *Chairman's Address: Function of the Minor (Usually Right) Cerebral Hemisphere in Language*—J. M. Nielsen, M. D., 727 West Seventh Street, Los Angeles.

The two cerebral hemispheres are structurally identical, but functionally very different. This applies especially to the function of the various areas concerned with language. After destruction of these anatomical areas on the major side, a patient is more or less incapacitated for the function formerly performed through (not to say by) these structures. The degree of disability will depend largely on the facility with which the corresponding area of the minor side can take over the function. This facility varies as much in various persons as does general facility in language or general intellect. Cases are presented to demonstrate this.

RECESS

Business meeting and election of officers.



IX

PATHOLOGY AND BACTERIOLOGY SECTION*

DAVID A. WOOD, M. D., *Chairman*
Stanford Hospital, San Francisco

GEORGE D. MANER, M. D., *Secretary*
657 South Westlake Boulevard, Los Angeles

ZERA E. BOLIN, M. D., *Assistant Secretary*
490 Post Street, San Francisco

First Meeting—Billiard Room

Monday, May 3, 1:30 p. m.

101. *Clinical and Postmortem Survey of the Incidence of Trichinosis in San Francisco*—James B. McNaught, M. D., Stanford University, San Francisco.

A general presentation of the subject of trichinosis, the life history of the parasite, symptomatology and pathology of the disease, diagnostic procedures, with particular attention to the use of Trichinella antigen, therapy, and preventive measures and the results of a Trichinosis survey in San Francisco.

102. *New and Simplified Physical Method for Blood Detection*—Frederick Proeschner, M. D., San Jose; Jesse Carr, M. D., University of California, San Francisco; and A. M. Moody, M. D., St. Francis Hospital, San Francisco.

Recent observation on the physical and physiochemical changes in full blood upon heating be-

tween the ranges of 500 degrees and 1000 degrees Fahrenheit have led to the development of several new principles in blood identification. While originally undertaken simply to ascertain whether or not blood could be identified as such above 500 degrees Fahrenheit, these studies have led to the conclusion that blood cannot only be identified at high temperatures, but that heating in the upper ranges, between 600 degrees and 800 degrees, actually causes physical changes in blood which are specific and which offer an easy, rapid, and safe method for medical-legal use.

103. *Chairman's Address: Changing Trends in Pathology*—David A. Wood, M. D., Stanford University, San Francisco.

104. *Quick Method for Photometric Determination of Total Protein and Albumen-Globulin Ratio in Body Fluids*—W. Parker Stowe, M. D., St. Luke's Hospital, San Francisco.

Method is based on precipitation of total proteins by 5 per cent sulphosalicylic acid. Globulin precipitation by half saturation with ammonium sulphate, centrifugation of precipitate, resolution in saline and reprecipitation with sulphosalicylic acid. Protein equivalents determined in Cenco-Sheard photometer after five minutes standing room temperature, against a known standard curve of protein, Kjeldahl determined. Galvanometer needle brought to 50 through W. & W. filter No. 74.

Tabulation of protein values corresponding to galvanometer readings is furnished.

105. *Blood and Bone Marrow Studies in Monocytic Leukemia*—Harry A. Wyckoff, M. D., Stanford University, San Francisco.

Cases of monocytic leukemia so far studied have exemplified the necessity of careful identification of both mature and primitive monocytes in the blood. Observations require repeated verification. This is the more true because of the close similarity of the clinical picture to that of other types of acute leukemia.

The sudden although transient appearance of considerable numbers of myelocytes and myeloblasts in the blood during the course of monocytic leukemia and the occasional finding of noticeable numbers of cells closely like or identical with mature and primitive monocytes in the blood of cases of acute myeloblastic leukemia suggest a close relationship of these cell types.

106. *The Development of Tumors in Female Mice Treated with 1:2:5:6 Dibenzanthracene, and Estrone*—Isabella H. Perry, M. D., University of California Medical School, San Francisco.

Spayed and intact mice were treated through their adult life by painting with 1:2:5:6 dibenzanthracene and estrone. A large number and variety of tumors developed. The results are interpreted as far as possible in regard to their own interrelationships and as related to other contemporary data and theories.

107. *Brief Discussion of Reticulum-Cell Sarcoma*—G. Y. Rusk, M. D., Mount Zion Hospital, San Francisco.

Brief discussion of reticulum-cell tumors and sarcomata of the breast. Illustrative cases of subcutaneous reticulum-cell sarcomata will also be shown.

108. *An Unusual Case of Diffuse Myeloma with Hyperproteinemia*—I. C. Schumacher, M. D., University of California, San Francisco; O. O. Williams, M. D., University of California, San Francisco (by invitation); G. S. Coltrin, M. D., University of California, San Francisco.

A case of myeloma of the plasma cell type, diffuse, showing hyperproteinemia with autohemagglutination, hemorrhage, and renal damage.

Woman sixty-four years of age, who had had a proclivencia for several years. Eight months ago she began to have hemorrhages from the nose, and experienced a gradual loss of weight. A diagnosis of multiple myeloma was made clinically on the basis of hemorrhage, autohemagglutination, renal

* Monitors: Z. E. Bolin, M. D., San Francisco, and Paul Michael, M. D., Oakland.

insufficiency, and hyperproteinemia. The only bone changes present were found in the skull. These were very minute areas of rarification.

At necropsy the bone marrow of all the bones showed a diffuse infiltration with plasma cells.

RECESS

Business meeting and election of officers.



Second Meeting—Billiard Room

Tuesday, May 4, 8:30 a. m.

109. *Stomach Mucosal Changes in Avitaminosis*—Alvin J. Cox, Jr., M.D., Stanford University, San Francisco.

Since 1923, ulcerative and proliferative lesions in some way related to deficient diets have been described in animals, and have been ascribed to vitamin deficiency as well as other causes. Evidence is presented to indicate that the effect of vitamin A deficiency upon gastric mucosa is not primarily an obvious structural change, but some modification rendering the mucosa more vulnerable to other injurious processes.

110. *Ochronosis*—G. R. Biskind, M.D., Mount Zion Hospital, San Francisco. (By invitation.)

Alcaptonuria and ochronosis are the incidental findings in a seventy-year-old white male who died from hemorrhage due to an arteriosclerotic ulcer of the stomach. Necropsy revealed the characteristic charcoal appearance of the cartilage, destruction of the left hip joint, and a large black prostatic calculus. A historical review, classification of reported cases and the chemical nature of the disease are discussed.

111. *Cystein Determinations in Finger and Toe Nails*—Zera Bolin, M.D., Mary's Help Hospital, San Francisco.

Cystein determination in nails. Method of use. Clinical results. Results of treatment of arthritis by sulphur as shown by cystein determinations.

112. *Acute Mononucleosis*—A. G. Foord, M.D., Huntington Memorial Hospital, Pasadena, and E. M. Butt, M.D., University of Southern California Medical School, Los Angeles.

A discussion of the laboratory methods of diagnosis. Significance of the heterophile antigen reaction in the diagnosis of suspected cases.

113. *Diverticula of the Jejunum*—Hugh A. Edmondson, M.D., University of Southern California Medical School, Los Angeles. (By invitation.)

Ten cases of acquired or "false" diverticula of the jejunum found in five thousand consecutive autopsies are presented. Less than one hundred have been reported. The one fatal hemorrhage occurred; the remainder were found incidentally.

Studies of etiology in relation to arteries and preservation of connective tissue compared with controls were made.

114. *Comparison of the Relative Merits of the Complement Fixation and Precipitation Tests in the Diagnosis of Syphilis*—W. H. Kellogg, M.D., 1700 Le Roy Avenue, Berkeley. (By invitation.)

(Above title suffices for abstract.)

Report of Nominating Committee.



Third Meeting—Auditorium

Wednesday, May 5, 1:30 p. m.

SYMPOSIUM ON LOBAR PNEUMONIA

This will be a joint meeting of the following sections: Medicine; Surgery; Obstetrics and Gynecology; Pediatrics; Pathology; Eye, Ear, Nose, and Throat; and Radiology.

The program of this joint meeting is printed under the fourth meeting of the General Medicine Section. (See page 20.)

X

PEDIATRIC SECTION*

EDWARD B. SHAW, M.D., *Chairman*
384 Post Street, San Francisco

E. EARL MOODY, M.D., *Secretary*
3780 Wilshire Boulevard, Los Angeles

HARTZELL H. RAY, M.D., *Assistant Secretary*
23 Second Street, San Mateo

First Meeting—Tower Room

Monday, May 3, 1:30 p. m.

115. *The Adrenal Cortical Syndrome in Little Girls—With Report of Surgical Cure and Complete Review of Literature*—William A. Reilly, M.D., 384 Post Street, San Francisco; Hans Lissner, M.D., 384 Post Street, San Francisco; Frank Hinman, M.D., 384 Post Street, San Francisco.

In little girls, adrenal cortical hyperfunction produces a unique and highly characteristic clinical picture. Early appearance of pubic hair and marked hypertrophy of the clitoris constitute outstanding symptoms; a sort of pseudosexual precocity with masculinization. Menstruation before eleven years is exceptional, likewise precocious mammary gland development. Syndrome differs definitely from true sexual precocity (very early menses, breast development, pubic hair, but no clitoris hypertrophy) produced by ovarian granulosa cell tumors. Early recognition of these adrenal tumors is important not only for surgical cure of the endocrinopathy, but to forestall death from metastases. (Illustrated by lantern slides.)

Discussion by E. Kost Shelton, M.D., Santa Barbara.

116. *The Endocrines and Behavior in Puberty*—Clara H. Spalding, M.D., 331 Eighth Street, Richmond.

Age scope, eleven to sixteen years. Problem is universal. It is important physically, emotionally, and socially. Physiology of pubescence showing development crisis with anatomic and endocrinologic changes and emotional responses. An endocrine basis for the precocious, normal, and retarded. Juvenile endocrinopathies and delinquency stress the need for early recognition, correct diagnosis, and correction of dyscrasias. Rationale of the misguided.

Discussion by S. N. Weil, M.D., Rodeo; Myrl Morris, M.D., San Francisco.

117. *Creatinuria of Childhood*—E. Kost Shelton, M.D., 34 West Micheltorena Street, Santa Barbara, and B. N. Tager, M.D., Cottage Hospital, Santa Barbara. (By invitation.)

Creatinuria was studied under basal conditions in fifty-six children, ranging in ages from six to thirteen years. Children with bone retardation of no more than two years and without frank hypothyroidism excreted more creatinin than the controls. Six frankly hypothyroid children with marked bone retardation showed diminished creatinuria. It is concluded that a low creatinin excretion in the presence of retarded bone development is corroborative evidence of hypothyroidism of childhood.

Discussion by Hans Lissner, M.D., San Francisco.

118. *Growth and Treatment of Dwarfs—Observations on Twelve Cases for Periods of One to Eight Years*—Leona M. Bayer, M.D., 2535 Vallejo Street, San Francisco, and Horac Gray, M.D., Stanford University School of Medicine, San Francisco.

The dwarfism was attributed to various causes. Age at beginning of observations ranged from one to eighteen years. All treated cases had control periods; five received growth hormone; four

* Monitors: Harry R. Lusignan, M.D., Monterey, and Margaret Swigart, M.D., Monterey.

received thyroid. Effectiveness of growth hormone is analyzed from our own material and from critical review of clinical literature.

Discussion by E. Kost Snetton, Santa Barbara; William P. Lucas, M. D., 490 Post Street, San Francisco.

119. *Phases of Adolescent Development in Girls*—Helen B. Pryor, M. D., Stanford University, Palo Alto.

A longitudinal study of adolescent development with cumulative records of physical and physiological data shows a close relationship between skeletal maturation and sexual development.

X-ray of hands show broad-built girls to have age equivalent greater than their chronological ages, while slender-built girls had age equivalents less than their chronological ages.

Discussion by William A. Reilly, M. D., San Francisco; William M. Happ, M. D., Los Angeles.

120. *The Physical and Mental Needs of Deaf Children*—Rexford Hoobler, M. D., Franklin Building, Oakland.

The causes of deafness as found at the California State School for Deaf. Preventive measures and phases of development stressed. Mental needs show necessity for nursery schools and special tests to determine mental capability. The state laws facilitating medical care explained.

Discussion by Mr. E. A. Stevenson, Superintendent of State School for Deaf, Oakland (by invitation); J. C. Edwards, M. D., Berkeley.

RECESS

Business meeting and election of officers.



Second Meeting—Directors Room

Wednesday, May 5, 8:30 a. m.

121. *The Value of Diet Analysis in Pediatric Practice*—Reita C. Hough, M. D., 1212 Medico-Dental Building, San Diego.

A series of cases upon which careful diet analysis have been made, showing most frequent errors discovered in the average diet and demonstrating the difficulties in arranging an adequate diet without the addition of accessory food factors. (Illustrated by lantern slides.)

Discussion by Helen B. Pryor, M. D., Palo Alto; E. Earl Moody, M. D., Los Angeles.

122. *Chairman's Address: The Practice of Pediatrics as a Specialty*—Edward B. Shaw, M. D., 384 Post Street, San Francisco.

123. *The Social Security Act*—Ellen S. Stadtmuller, M. D., Bureau of Child Health, California State Health Department, San Francisco.

I. Provisions of the Act. (1) Promotion of maternal and child health in rural areas and among special groups. (2) Expanding and developing local facilities. (3) Technical requirements such as matching, reporting, State participation in expenditure, etc. (4) Coöperation with medical group.

II. Presentation of figures and charts upon which the needs for work in California are based.

III. Plans for service. (1) Districting the State. (2) County nurses placed in areas not provided with this service. (3) Prenatal service. (4) Preschool conferences. (5) Dental program. (6) Educational possibilities.

IV. Crippled children's program. (1) Program under the State law of 1927. (2) Extension of the program under the Act. (3) Report of progress.

Discussion by Oscar Reiss, M. D., Los Angeles; Clifford Sweet, M. D., Oakland; Francis Scott Smyth, M. D., San Francisco.

124. *Mental Hygiene Viewpoints on Some Common Pediatric Problems*—Forrest N. Anderson, M. D., 1325 West Adams Street, Los Angeles.

Concepts of psychiatry as an attitude versus a technique and their application to views on the psychosomatic development of the child. What

help may be derived from these psychiatric contributions on several common problems of childhood: eating, toilet habits, behavior management, etc.

Discussion by George Kryder, M. D., Glendale.

125. *Nephritis in Childhood: A Survey*—Howard R. Cooder, M. D., 3875 Wilshire Boulevard, Los Angeles.

Nephritis divided into three classes. Fifty cases admitted to the Los Angeles Children's Hospital classified.

Group I. A majority became symptom-free, with normal urine findings within a month or less.

Group II. A large number have findings lasting longer, but were cured within nine months.

Group III. A small percentage have symptoms and findings persisting and advance to chronic nephritis or nephrosis.

Discussion by William W. Belford, M. D., San Diego; Louis M. Earle, M. D., Los Angeles.



Third Meeting—Auditorium

Wednesday, May 5, 1:30 p. m.

SYMPOSIUM ON LOBAR PNEUMONIA

This will be a joint meeting of the following sections: Medicine; Surgery; Obstetrics and Gynecology, Pediatrics; Pathology; Eye, Ear, Nose, and Throat; and Radiology.

The program of this joint meeting is printed under the fourth meeting of the General Medicine Section. (See page 20.)



XI

RADIOLOGY SECTION*

WILLIAM E. COSTLOW, M. D., *Chairman*
1407 South Hope Street
Los Angeles

JOHN D. LAWSON, M. D., *Secretary*
California State Life Building
Sacramento

First Meeting—Art Gallery

Monday, May 3, 1:30 p. m.

126. *Chairman's Address: Radiation Therapy—Its Status in Medical Practice*—William E. Costlow, M. D., 1407 South Hope Street, Los Angeles.

127. *The Application of Physics to Roentgen Therapy*—Robert E. Pugh, Jr., 1944 Summit Avenue, Pasadena. (By invitation.)

A presentation of an understandable definition of the r-unit and its use in assuring exact duplication of successful dosages in roentgen therapy, and a more lucid explanation of the fundamental physical concepts determining the choice of therapy technique. The present status of therapy calibration and the most desirable method of reporting dosage values in the literature and clinical records are discussed together with some notes on superficial therapy and its limitations.

128. *The Complications of X-Ray Therapy*—Richard T. Taylor, M. D., 1212 Shatto Street, Los Angeles.

A summary of various untoward and unforeseen occurrences which enter into the practice of roentgen therapy.

129. *Radiation Treatment of Squamous-Cell Carcinoma*—Clyde K. Emery, M. D., 445 South Kingsbury Drive, Los Angeles.

Comparative radiosensitivity of squamous-cell carcinoma in various locations in the body, lethal doses with x-ray and radium, the dangerous limits and the sequela to various types of radiation.

* Monitor: Charles A. Galligan, M. D., Monterey.

130. *Unfiltered X-Ray as a Treatment for Superficial Malignancies*—William H. Sargent, M. D., Samuel Merritt Hospital, Oakland.

This discussion is based upon observations made during the last six years of the use of large doses of unfiltered x-ray in the treatment of superficial malignancies. Its range of action, the technique, the possible causes of failure, and the results so far obtained.

RECESS

Meeting of the Pacific Roentgen Club.



Second Meeting—Tower Room

Wednesday, May 5, 8:30 a. m.

Business meeting and election of officers.

131. *Experience with the Rotating Anode Tube*—Robert A. Powers, M. D., Medico-Dental Building, Palo Alto.

A discussion of advantages and disadvantages of this apparatus as related to radiography.

132. *Case Reports of Lymphosarcoma of the Upper Jejunum*—Russell Gates, M. D., Cottage Hospital, Santa Barbara.

Two cases of lymphosarcoma of the upper jejunum will be presented in detail with histories, roentgenographic, surgical and pathologic findings. The lesion in each case was clearly demonstrated by x-ray before operation.

133. *Roentgenological Examination of the Cervical Vertebra*—Charles S. Capp, M. D., University of California Hospital, San Francisco.

Lantern slide demonstration of the common and uncommon anomalies of development, their demonstration, recognition, and correlation of their clinical significance and importance. The methods of special examination for bony lesions originating in or secondarily involving the vertebrae will be demonstrated, and a discussion as to the differential diagnosis in each type of case will be presented.

134. *The Shape of the Female Pelvis and Its Clinical Significance: Further Studies*—L. H. Garland, M. D., 450 Sutter Street, San Francisco.

Female pelvises may be classified according to definite architectural or morphologic characteristics into four main types. These four main types are termed gynecoid, android, anthropoid, and platypelloid. The roentgen technique and methods of interpretations are outlined and certain conclusions regarding the reliability of interpretation, based on approximately three hundred examinations, are given. The clinical significance of the various types of pelvis are recorded. The feasibility of combining in a relatively simple examination both pelvimetry and pelviography is discussed.

135. *The Relation of the Orthopedist to the Radiologist*—Donald McNeil, M. D., Medico-Dental Building, Sacramento.

A practical discussion of the necessary close relation of these specialties with suggestions as to mutual assistance through coöperation.

136. *Removal of Lead Shot From Vitreous by Use of Biplane Fluoroscope*—W. E. Borley, M. D., Stanford University Hospital, San Francisco, and Edward Leef, M. D., Stanford University Hospital, San Francisco.

Description of localization and removal of lead shot from the vitreous through the use of special forceps and biplane fluoroscopy. A review of the literature and photographs of the equipment used.

Third Meeting—Auditorium

Wednesday, May 5, 1:30 p. m.

SYMPOSIUM ON LOBAR PNEUMONIA

This will be a joint meeting of the following sections: Medicine; Surgery; Obstetrics and Gynecology; Pediatrics; Pathology; Eye, Ear, Nose, and Throat; and Radiology.

The program of this joint meeting is printed under the fourth meeting of the General Medicine Section. (See page 20.)



XII

UROLOGY SECTION*

ADOLPH A. KUTZMAN, M. D., *Chairman*
1930 Wilshire Boulevard, Los Angeles

LLOYD KINDALL, M. D., *Secretary*
400 Twenty-Ninth Street, Oakland

First Meeting—Tower Room

Tuesday, May 4, 8:30 a. m.

137. *Chairman's Address: Anuria*—Adolph A. Kutzmann, M. D., 1930 Wilshire Boulevard, Los Angeles.

138. *Plastic Operation on the Pelvis of a Solitary Kidney*—John A. Dougherty, M. D., 3115 Webster Street, Oakland.

A female, age two years; gave past history of fever, chills, and pyuria; duration, one year. Investigation revealed a right, infected hydronephrosis with a stricture at the uteropelvic junction and an absence of a kidney on the left. Description of operation and subsequent history. Lantern slides before and after operation. Review of literature.

Discussion by Frank Hinman, M. D., San Francisco; L. P. Player, M. D., San Francisco.

139. *Enterovesical Fistula with Paraffinoma*—S. T. Ragan, M. D., 3875 Wilshire Boulevard, Los Angeles.

A case of enterovesical fistula, secondary to paraffin injection for the cure of hernia, is reported. A short review of the literature follows. Symptomatology and diagnostic methods are emphasized. Motion pictures in color demonstrate the lesion and the author's technique of repair.

Discussion by Carl F. Rusche, M. D., Los Angeles.

140. *Urological Surgery in Tuberculosis Patients*—J. C. Negley, M. D., 527 West Seventh Street, Los Angeles. Collaborator, F. M. Miller, M. D., Olive.

There is a belief among the laity and the profession that surgery in tuberculous patients is not warranted by the results obtained and the risk entailed. The authors review histories of some 300 or 400 tuberculous patients who have had surgery or cystoscopic studies. Reciting end-results as to condition for which surgery was done and end-results as to patients' general condition.

Discussion by Thomas E. Gibson, M. D., San Francisco.

141. *Ureteral Papillomas as a Cause of Hydronephrosis*—Jay J. Crane, M. D., 1921 Wilshire Boulevard, Los Angeles.

This paper deals with the diagnosis and treatment of papillomas of the ureter as well as the frequency with which it appears in our urologic clinics at Los Angeles County General Hospital. The summary takes up diagnosis by intravenous and retrograde pyelograms, with a review of the cases.

Discussion by James R. Dillon, M. D., San Francisco.

* Monitors: Thomas I. Buckley, M. D., Oakland, and Morrell Veckl, M. D., San Francisco.

142. *Believe-It-or-Nots in Urology for 1937*—Wirt B. Dakin, M. D., 523 West Sixth Street, Los Angeles. These reports were selected from a large group of urologic cases for their unbelievable nature and outstanding interest. They include cases of strange pathologic conditions and anomalies; unique findings and results in surgery; rare etiologic and curative factors.

RECESS

There will be a Urology Section luncheon at 12:30 p. m., May 4, 1937, at which Frank Hinman, M. D., of San Francisco, will present a summary of the urologic meetings attended by him in Europe in 1936, namely, the Clinical Society in London, the International Congress in Vienna, and an extemporaneous extension of this conference in Budapest. Please make reservations for this luncheon with the secretary as early as possible.



**Second Meeting—Tower Room
Wednesday, May 5, 1:30 p. m.**

143. *Brucellosis of the Male Genitalia*—Thomas I. Buckley, M. D., 411 Thirtieth Street, Oakland.

The paper deals with a review of *Brucella* infection of the male genital tract with a case report on involvement of the testicle. Gross and microscopic sections of lesions produced, experimentally, in animals will be shown.

Discussion by Morrell Vecki, M. D., San Francisco.

144. *Differential Diagnosis of Acute Fatty Necrosis in the Scrotum*—Frank Hinman, M. D., 384 Post Street, San Francisco, and Clark Johnson, M. D., 384 Post Street, San Francisco.

Two instances of fat necrosis in the scrotum in young boys have been encountered. The onset was acute. The differential diagnosis was difficult, the final diagnosis being made at the operating table. Discussion of the clinical picture, etiology, pathology, and treatment.

Discussion by A. Elmer Belt, M. D., Los Angeles.

RECESS

Business meeting and election of officers.

145. *Water Balance in the Surgical Patient*—Donald A. Charnock, M. D., 727 West Seventh Street, Los Angeles.

Adequate fluids during postoperative procedures is often an important factor in the patient's recovery. Fluid loss must be carefully balanced with liquid intake. The factors of fluid elimination are discussed, together with methods for their balance.

Discussion by Carl Rusche, M. D., Los Angeles.

146. *Sympathetic Surgery in Bladder Infections*—Felix Pearl, M. D., 450 Sutter Street, San Francisco, and Bernard Strauss, M. D., 999 Sutter Street, San Francisco.

The authors review the pertinent anatomy and physiology of the autonomic nerve supply to the bladder, and discuss the basis for operations on the sympathetic nerves in the treatment of neurogenic vesical dysfunction and painful bladder states. The operative technique is described and illustrated. Cases are reported.

Discussion by Sidney Olsen, M. D., San Francisco.

147. *Vesicosigmoid Fistula*—Paul A. Ferrier, M. D., 65 North Madison Avenue, Pasadena.

(1) Causes of vesico-sigmoid fistula. (2) Early symptoms. (3) Treatment. (4) Report of two cases.

Discussion by Irving Wills, M. D., Santa Barbara.

148. *Specificity of Nonspecific Urethritis*—James Steinberg, M. D., Professional Building, Los Angeles.

Series of one hundred consecutive cases of nonspecific urethritis establishing the etiologic agent to be a certain food or drink for which each individual has been discovered to have a specific sensitization or idiosyncrasy, the elimination of which has brought about a complete cure in most cases and marked improvement in others, with methods of procedure and tabulation of results.

Discussion by Louis C. Jacobs, M. D., San Francisco.

IX—COMMERCIAL EXHIBITS

(For alphabetical list of Commercial Exhibits, see page 9)

Commercial exhibits are located in the main lobby and on the ground floor of Hotel Del Monte. Members are urged to call on these exhibitors and form their acquaintance. These business men merit your patronage.

The following exhibitors will occupy booths:

Aloe Company, A. S., 932 South Hill Street, Los Angeles, Booths Nos. 19 and 20.

Our exhibit consists of a complete line of stainless steel surgical instruments, which are rapidly replacing the chrome and nickel-plated lines; our *Contempora* line of wooden furniture for the physician's office; our latest ultra short-wave diatherm with the Elliott Treatment Regulator; other physical therapy apparatus approved and accepted by the Council of Physical Therapy of the American Medical Association.

Four years have been spent in developing our laboratory department. We are sure that the profession will be greatly interested in consolidating their laboratory needs into their surgical supplies source.

Ayerst, McKenna & Harrison, Ltd., 781 Williams Street, Montreal, Canada. Booth No. 2.

Baxter, Don, Inc., 1505 Gardena Avenue, Glendale, Booth No. 5.

Baxter's Intravenous Solutions—Don Baxter, Incorporated, Glendale, Chicago and New York, will display their Council accepted solutions in Vacoliter in Booth 5. Baxter's Double-size Vacoliter (200 cc.) for continued Venoclysis will be demonstrated for physicians interested in prescribing doses larger than 1,000 cc.

Bilhuber-Knoll Corp., 154 Ogden Avenue, Jersey City, New Jersey. Booth No. 9.

In prescribing for your patients you can expect highly satisfactory results with the reliable newer preparations of Bilhuber-Knoll. In heart diseases, Theocalcin aids in reducing dyspnoea and edema, and attacks of angina pectoris. Dilaudid hydrochloride, the powerful analgesic, for pain relief in cancer, terminal tuberculosis, surgery and obstetrics; as well as a cough sedative. The non-barbiturate sedative and hypnotic, Bromural, and the quickly acting cardio-respiratory stimulant, Metrazol, are of much interest in their fields of usefulness. Representatives will be pleased to discuss these products with you.

Borden Company, The, 354 Madison Avenue, New York City, New York. Booth No. 31.

Calso Company, The, 524 Gough Street, San Francisco. Booth No. 25.

Physicians are cordially invited to visit booth No. 25, where they will find palatable and sparkling, ice cold Calso Water. (Alkaline.) If you will leave with us your room number, we will see that your Calso needs will be supplied.

Coca-Cola Company, The, Atlanta, Georgia. Booth No. 14.

Coca-Cola will be served to the delegates with the compliments of The Coca-Cola Company.

Cutter Laboratories, Berkeley. Booth No. 13.

Cutter Laboratories exhibit consists of specimens and literature of their complete line of California-produced vaccines, antitoxins, and allied specialties. Featured are their simplified but effective California test and treatment

sets for hay fever and their line of dextrose solutions in Saitiflasks.

DeVilbiss Company, The, Toledo, Ohio. Booth No. 22.

The complete DeVilbiss line of atomizers, steam vaporizers, and nebulizers will be on display. Specially featured in the exhibit are illustrations graphically showing the superior coverage afforded by the atomizer in the application of solutions to the nose and throat. These illustrations are based on x-ray research carried on by DeVilbiss under ethical supervision.

Copies of the illustrations for reference may be secured from A. O. Narveson, DeVilbiss representative in charge of the display.

Dictograph Products Company, Inc., 457 Powell Street, San Francisco. Booth No. 15.

Exhibit of acousticon hearing aids for hard of hearing, new aurogauge for prescribing hearing aids, church acousticons and portable group hearing aids, silent radios, telematic inter-office communication, Glolite cigarette lighters, Packard Lifetime Lektro Shavers.

H. G. Fischer & Company, 450 Sutter Street, San Francisco. Booth No. 37.

This is the twenty-fifth anniversary of the H. G. Fischer & Company, manufacturers of x-ray, short wave equipment, physical therapy equipment and their accessories.

The exhibit will consist of mobile x-ray and other physical therapy equipment and their accessories.

General Electric X-Ray Corporation, 2012 Jackson Boulevard, Chicago. Booth No. 17.

Gerber Products Company, Fremont, Michigan. Booth No. 1.

Gerber's strained foods for infant feeding and special diets will be on display in Booth No. 1. We invite you especially to stop and see the new product—strained apricots and apple sauce.

Literature will be available for examination, including both reprints for professional use and booklets which are available for distributing to your patients.

Golden State Company, Inc., 425 Battery Street, San Francisco. Booths Nos. 27 and 28.

Heinz, H. J., Corporation, 2998 San Pablo Avenue, Berkeley. Booth No. 30.

H. J. Heinz Company, makers of the 57 Varieties, invites you to visit their exhibit featuring strained foods, breakfast cereals, and olive oil.

Stop for a cold drink of Heinz' Tomato Juice and register for the third edition of the Nutritional Chart. The two previous editions were so enthusiastically received that it was thought advisable to make frequent revisions in order to keep abreast with the rapid advances in the field of nutrition.

Kellogg Sales Company, 155 Montgomery Street, San Francisco. Booth No. 26.

Lederle Laboratories, Inc., 450 Sutter Street, San Francisco. Booth No. 11.

Libby, McNeill & Libby, Chicago. Booth No. 3.

The most outstanding recent development in the science of infant feeding—Libby's Homogenized Foods. This new process mechanically ruptures the food cells of vegetables, fruits, and cereals, and refines the cellulose tissue, releases the contained nutriment, and makes these foods more easy to digest and more completely assimilated. Photomicrographs of strained and homogenized foods graphically illustrate the advantages of the newer process. The research laboratories of Libby, McNeill & Libby invite you to inspect their display in Booth No. 3.

Liebel-Flarsheim Company, 303 West Third Street, Cincinnati, Ohio. Booth No. 32.

Mead, Johnson & Company of California, 670 Third Street, San Francisco. Booth No. 12.

Dextri-Matrose, Dextri-Maltose with Vitamin B

Mead's Standardized Cod-Liver Oil

Mead's Yeast Tablets and Yeast Powder

Mead's Casec

Mead's Protein Milk

Mead's Lactic Acid Milk

Mead's Pablum and Cereal

Mead's Oleum Percomorphum

Mead's Cod-Liver Oil fortified with Percomorph Liver Oil

"Servamus Fidem"

Medical Protective Company, The, Wheaton, Illinois. Booth No. 21.

The Medical Protective Company is represented at Booth No. 21, where you are invited to call. Medical Protective Service is an institution of the medical profession whose legal liability problems we have concentrated upon for thirty-eight years. Bring your professional liability questions and problems to Booth No. 21.

Mennen Company, The, 345 Central Avenue, Newark, New Jersey. Booth No. 36A.

The Mennen Company, Newark, New Jersey, will exhibit their two famous baby products—Antiseptic Oil and Antiseptic Borated Powder. Be sure to register at their exhibit and receive samples of these products, as well as the opportunity to participate in the lucky number drawing for two de luxe fitted leather travel kits.

Merck & Company, Inc., Rahway, New Jersey. Booth No. 6.

A display of interesting new products will be featured at Booth No. 6. A booklet containing useful anatomic charts of the autonomic system is available upon request. Attendants will gladly supply full information regarding such new preparations as Mecholyl (a parasympathetic stimulant), and Cebione (crystalline vitamin C).

Middlewest Instrument Company, 1870 Ogden Avenue, Chicago, Illinois. Booth No. 29.

Middlewest Instrument Company, in Booth No. 29, will feature as their display the Jones motor basal metabolism apparatus.

A special feature of this unit is that it contains no water and requires no calculation in the determination of the basal metabolic rate.

The attendant in charge of the exhibit, Mr. Baransky, will be glad to make demonstration of the technique. He will also make metabolism tests to anyone wishing to have this done. No obligation.

Pet Milk Sales Corporation, Saint Louis, Missouri. Booth No. 16.

The Pet Milk Company display consists of a miniature plant. This exhibit shows in detail the various steps in the process of making Irradiated Pet Milk from the receiving room through the evaporator, the irradiator, the homogenizer, as well as through the sterilizer.

Petrolagar Laboratories, 8134 McCormick Boulevard, Chicago. Booth No. 10.

There are now five types of Petrolagar available for the specialized treatment of constipation.

Each type serves a special purpose, and enables the physician to fit the treatment to the particular need of the patient. Samples and further information may be obtained at Booth No. 10.

Philip Morris & Company, Ltd., 119 Fifth Avenue, New York. Booth No. 7.

Philip Morris & Company, Ltd., Inc., will demonstrate the method by which it was found that Philip Morris cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than ordinary cigarettes in which glycerine is employed.

S. M. A. Corporation, Cleveland, Ohio. Booth No. 8.

S. M. A. Corporation will exhibit, at Booth 8, their line of infant diet materials and Smaco Vitamin products:

S. M. A. for infants deprived of breast milk; Hypo-Allergic Milk and Alerdex, for allergy patients; Carotene (pro-vitamin A) for vitamin A deficiencies, both in adults and children; and other milk and vitamin products.

Stacey, J. W., Inc., Flood Building, San Francisco. Booth No. 18.

In Booth No. 18 there will be found the new medical and scientific books, comprising the largest display of such publications shown at the State meeting. J. W. Stacey, Inc., of San Francisco, publishers and distributors of medical books, cordially invite you to inspect the volumes at your leisure.

Stokeley Brothers & Company, Inc., South East Street, Indianapolis. Booth No. 4.

Now there is a complete line of Stokeley's Strained Foods for baby.

Strained vegetables, soups, fruits and cereals—specially prepared, from choice products by methods which retain natural flavor and food value in high degree. Correctly seasoned for absolute uniformity and protected in golden enamel lined cans, these foods have a natural, delicious flavor that baby really likes.

Travers & Hennig, Inc., 429 Sutter Street, San Francisco. Booth No. 36B.

Travers & Hennig, Inc., one of the oldest surgical supply houses of Northern California, will occupy Booth No. 36B. They will particularly specialize and show the Allison Directoire and Hamilton Steeltone physicians' office furniture.

The National line of diagnostic instruments and cauterizers of advanced design will also be shown.

Vitamin Products Company, 2023 West Wisconsin Avenue, Milwaukee. Booth No. 23.

A booklet, called *Vitamin News*, may be had with the compliments of the Vitamin Products Company by registering at their booth, which also entitles you to receive subsequent issues of *Vitamin News*, which are mailed monthly.

Information may also be had on their full line of vitamin concentrates, obtained from natural food sources, from A to G, inclusive, in tablet form.

Western Surgical Supply Company, Ltd., 1926 Wilshire Boulevard, Los Angeles. Booths Nos. 33 and 34.

We invite you to see our exhibit, Booths Nos. 33 and 34. Come and peruse at your convenience. We expect to show several new items, besides the most up-to-date, modern equipment for your approval.

Zweegman School for Medical Secretaries, 450 Sutter Street, San Francisco. Booth No. 24.

X—DEL MONTE AND THE MONTEREY PENINSULA

DEL MONTE

An observing traveler once said that Del Monte is all things—at once. His description, however brief, doesn't come far from the mark. For within Del Monte's vast estate of 20,000 acres is nearly every description of recreation and sport imaginable.

Golf.—Would you golf? Within a three-mile radius of Del Monte are five courses; more, in such a concentrated area, than is to be found elsewhere in the world. One of these courses, famous Pebble Beach, was the scene in 1929 of the National Amateur championship. At that time Bobby Jones called it the most picturesque and playable layout of his experience. Cypress Point, Del Monte, the Monterey Peninsula Country Club courses, and Pacific Grove's fine municipal course complete the list.

Tennis.—Is tennis your sport? Del Monte has eleven courts. Every June witnesses the Del Monte tennis championship when fine players from all parts of the coast gather to match their skill.

Trapshooting.—Do you go in for trapshooting? Del Monte has the largest and one of the best equipped set of traps in the country. Official gathering place of the Pacific International Trapshooting Association, the Del Monte grounds present the sport at its best. State and sectional tournaments are held there annually as well as the yearly sports powwow of the California Indians in April.

Fishing and Hunting.—Perhaps your sport is fishing. Or hunting. There, too, Del Monte offers the best to be found. But one hour by motor from Del Monte, up the Carmel Valley, is San Clemente, Del Monte's guest ranch. Adjoining and extending into the great national forest that lies between the Salinas Valley and the coast, San Clemente offers the nimrod and hunter their heart's desire. Then, of course, there are the world-famous waters of Monterey and Carmel Bays for deep-sea fishermen.

Swimming.—Perhaps your favorite pastime is swimming, and the popular and healthful fad of sun-bathing. Del Monte provides complete facilities to satisfy your desires. The Roman Plunge in the beautiful and spacious hotel park has heated salt water and is open the year round, with a smaller and safe plunge for children. The Beach Club at Pebble Beach has an open-air tank at the water's edge. Then there are the white sandy beaches on Monterey and Carmel Bays and the Pacific Ocean to enjoy surf bathing, and the ol' swimmin' hole at the Monterey Peninsula Country Club is another favorite spot.

Trails.—Have you tried the bridle paths at Del Monte? If not, you have missed a treat. There are more than one hundred miles of privately owned and signed scenic paths in the forest and along the beaches. A stable of fine mounts is maintained. By all means bring your riding togs.

MONTEREY

Monterey Peninsula is richly endowed with travel interest. Here are attractions for everyone. Historic-minded motorists who travel with guide book and camera, and others who merely poke around for the fun that's in it, both find their heart's desire within California's famous "Circle of Enchantment."

Good roads, clearly marked, lead the willing motorist to points of special charm and reveal vistas and scenes which artists have chosen to proclaim the most beautiful anywhere. A trip to the Monterey Peninsula and along the coast to the Big Sur may indeed be called a trip so memorable as never to be forgotten.

The city of Monterey is in itself enough reward for having made the trip. Monterey was discovered by the Spaniard Cabrillo in 1542. He called it "Bay of the Pines," and as such was it known until 1602, a decade before the Pilgrims landed on eastern shores, when Vizcaino rediscovered it and called it Monterey (King of the Forests) after the Comte de Monterey, then Viceroy of Mexico. Over a century and a half elapsed before white men again set foot on the soil of California. Then came Portola in 1770, who established the Monterey Presidio, and Padre Junipero Serra, who founded the San Carlos Mission.

Monterey was a gay place under Spanish rule. All the glamor of old Spain held forth then, and life there was a perpetual care-free fiesta. In 1821 Mexico threw off the Spanish yoke and a period of unrest followed, culminating in 1846, when Commodore Sloat raised the Stars and Stripes over the historic Customs House and Monterey became an American possession.

Monterey abounds with historic and beautiful points of interest. Visitors there would do well not to miss the following landmarks: *San Carlos Church*, founded in 1770 by Junipero Serra and once the place of worship for representatives of the Spanish throne, governors and Presidio officers; *Monterey Presidio*, established by Portola in 1770 and prominent throughout Monterey's history; *First Theater in California*, used by picturesque strolling players as early as 1847. Of great interest, this building is now open as a public museum. *Customs House*, over which have flown the flags of Spain, Mexico and the United States; *Colton Hall*, first capitol building of California. Here was drafted the constitution of California. *Stevenson House*: The beloved Robert Louis Stevenson spent three months here in 1879, and wrote one or two of his memorable works in Monterey. Praise of Monterey and its coast is to be found in some of his books.

Seventeen Mile Drive.—No trip to the Monterey Peninsula is complete, of course, without including the world-famous Seventeen Mile Drive. The combinations of pines, age-old cypress and the sparkling blue of the Pacific is one that hundreds of artists have honored with their canvases.

PRE-CONVENTION BULLETIN*

FOREWORD.—The official reports which follow are to be presented at the coming session of the House of Delegates.

Delegates are urged to familiarize themselves with their contents.

Members, likewise, are requested to become familiar with the recommendations of these reports, and to discuss them with other members and delegates.

* * *

I

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the Members of the House of Delegates and the Members of the California Medical Association:

Pursuant to a well-established custom and good usage, your general officers are giving to you, and through you, to the membership, an account of their stewardship for the past year.

The House of Delegates is the final source of authority in the California Medical Association. The general officers, under the Constitution and By-Laws, function during the intervals of the House's meeting.

As your president during the past year, I have an apology to make: I have not been able to equal the record of meetings held with component county societies made by my immediate predecessors.

Until recently the general officers, excepting the councilors, met only occasionally with the local societies. Two years ago President Toland deemed it his duty and pleasure to introduce the then new secretary, Doctor Warnhuis, to the members-at-large, and so they visited many county associations up and down the State.

Last year, President Peers, with his ever present habit of doing things well and of excelling, visited every county association in California. This is a record to which I have not been able to attain. I have, however, visited many of the societies, both in the North and in the South, with the President-Elect, Speaker of the House, Secretary, and various Councilors. I had gone, too, on a number of these society-visiting tours throughout the State with both Doctor Toland and Doctor Peers during their terms of office. I have also attended many medical meetings in my home town—Los Angeles having an average of about one medical meeting daily throughout the year.

The county associations throughout the State, I am pleased to report, are in a most prosperous condition. Their meetings are very well attended, much interest is manifested, and their officers apparently are doing their work well.

Looking back over nearly forty years of progress in medical organization work in California, we cannot but be greatly encouraged. Far more interest is being shown than ever before. Notwithstanding the recent years of depression and the general increase in dues, the membership has uniformly increased each year.

While California ranks fourth among the American states in number of members, our percentage of members, based upon the number of licentiatees, is among the lowest, being only about 53 per cent. This is due largely to the number of retired and semiretired licentiatees in the State. A survey made by the Secretary's office shows that about 85 per cent of the really eligible or "desirable" licentiatees are members. On this basis two counties—Imperial and Santa Barbara—rank 100 per cent, while the following counties rank 95 per cent or higher: Humboldt, 97 per cent; Fresno, 96 per cent; Marin, 97 per cent; Monterey, 96 per cent; Sacramento, 95 per cent; San Bernardino, 95 per cent.

A recent survey shows that there are nearly six hundred men in each of the metropolitan counties—Los Angeles and San Francisco—who are not members, but who should be. We would urge a renewed campaign for members in these two counties.

It is estimated that in the list of California licentiatees there are 500 nonresidents, 50 full-time teachers, and 500

* Section 3, Article XII, of the California Medical Association Constitution states, in part: "The Association, prior to the annual session, shall print a 'Pre-Convention Bulletin,' which shall contain reports of officers and committees. . . . A copy of the 'Pre-Convention Bulletin' shall be given to each delegate and alternate on or before registration."

full-time men and women, including internes and residents, in federal, state, and county institutions.

As your president I have attended regularly the meetings of the Council, Executive Committee, Trustees, Committee on Public Relations, and other committees of which the president is ex officio a member. These groups are all composed of sincere, able and energetic men. No doubt much more work is done by them than is usually appreciated by the membership at large.

The State Legislature is now in session. This entails an enormous amount of work by the Committee on Public Policy and Legislation, of which Dr. Junius B. Harris of Sacramento has been chairman for several years. The medical profession in California is under deep obligation to this committee.

Another hard-working group is the Department of Public Relations, of which Dr. Charles A. Dukes is chairman. Due to its multiplicity of activities it is of great importance.

After the meeting at Coronado a year ago, Doctor Toland and his Committee on the Scientific Exhibit in the Hall of Medical Sciences at the California Pacific International Exposition at San Diego continued, with the local committee from the San Diego County Society, an active interest in the exhibit, making frequent visits to it, till the Fair closed in the fall.

Reports in regard to the interest shown in this medical exhibit by the public were pleasing. It was stated that only one other building at the Exposition had as many visitors as did the Medical Science Building.

The Committee on Postgraduate Activities has continued the good work it began a year ago, and has recently enlarged its personnel with the aim of broadening its activities. In future, the deans of the five medical schools in the State, the Tuberculosis and Heart Associations, and probably two of the Bureaus of the State Department of Public Health, will cooperate with this committee in presenting postgraduate clinics with the different county societies outside the larger centers of population.

As the time approaches when I shall turn over to my successor the gavel of the president, I wish to extend my most cordial thanks to the officers, committeemen, and members generally who have contributed so much toward making the past year one of progress to our Association.

I wish again to thank you for the honor bestowed in making me your president, for it is indeed a very great honor—and I shall always esteem it such.

Respectfully submitted,

Edward M. Palette, *President*.

REPORT OF THE PRESIDENT-ELECT

To the President and the House of Delegates:

Your president-elect has attended all but one of the meetings of the Council and the Executive Committee. In addition, he has visited several county societies in company with general officers and councilors. He has been and is now serving on a Special Committee of the Council, requested by the United States Public Health Service Surgeon-General to act in liaison on the State's venereal disease program.

In conclusion, your president-elect embraces this opportunity to express a very genuine personal appreciation for the consideration and courtesies extended to him by many members.

Respectfully submitted,

Howard Morrow, *President-Elect*.

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

In addition to presiding over the deliberations of the 1936 session of the House of Delegates, the Speaker has attended all meetings of the Council and the Executive Committee, and he has also cared for such special committee assignments as have been appointed by the chairman of the Council.

The delegates are urgently requested to read the reports of the year's work of the Association, as published in the Pre-Convention Bulletin, and to be prompt in attendance at all meetings, in order that intelligent action may be taken on all matters brought before the House. This will insure both rapid and efficient handling of its business and an early adjournment.

Respectfully submitted,

W. W. Roblee, *Speaker.*

REPORT OF THE CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

In order that the Council may present to the House of Delegates a report that embraces all of its official actions up to the time that the House of Delegates convenes, the annual report of the Council will be presented at the first meeting of the House of Delegates.

Respectfully submitted,

Morton R. Gibbons, *Chairman.*

REPORT OF SECRETARY-TREASURER

To the President and the House of Delegates:

Your secretary-treasurer, appreciative of the honor and privilege, respectfully submits to your body, and through you to the House of Delegates and members, this annual report for the calendar year of 1936. Interspersed through the factual statements there will be found comments and explanatory paragraphs that amplify and clarify Association activities and business transactions.

It is pertinent to preface this report by the general statement that we have passed through a year to which we may point with justifiable pride as one in which our Association attained in full degree the aims and purposes of organization, and discharged its obligations to the public and to members in a most commendable manner. Our house is well in order.

MEMBERSHIP

The numerical strength of our Association, the fourth largest in the American Medical Association federation, is represented by the following figures:

On January 1, 1936, our membership was 5,402. Our membership on January 1, 1937, is classified as follows:	
Members in good standing.....	5,492
Honorary members.....	9
Retired members.....	60
Associate members.....	6
Total members.....	5,567

A net gain of 170 members is quite satisfactory, and discloses that our Association has affiliated 83 per cent of the eligible and desirable licensed physicians and surgeons in California. We may point to this record with considerable pride, as the average for the country is about 63 per cent. The fact is observed that, as an Association, we are representative of the profession in California and can rightfully claim that we are its authoritative spokesman.

County society officers and committees, too, merit generous credit and appreciation for their efforts to obtain the affiliation of desirable members.

MEMBERSHIP BY COUNCILOR DISTRICT

First District—C. L. Emmons, M. D., Councilor

Imperial	27
Orange	109
Riverside	69
San Bernardino	137
San Diego	258
	600

Second District—Carl R. Howson, M. D., Councilor

Los Angeles	2,200
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Third District—Henry J. Ullmann, M. D., Councilor

Kern	48
San Luis Obispo	29
Santa Barbara	102
Ventura	35
	214

COUNTY AFFILIATIONS

County	Members		Delinquents	Deaths	Loss	Gain	Estimated No. Eligible Men Not Affiliated	Per Cent of Eligible Men Now Affiliated
	1936	1935						
Alameda	476	459	19	4	.....	17	25	91
Butte	24	24	0	2	.....	.....	5	86
Contra Costa	49	44	0	1	.....	5	9	87
Fresno	112	108	2	2	.....	4	4	96
Humboldt	30	28	0	0	.....	2	1	97
Imperial	27	24	2	0	.....	3	0	100
Kern	48	46	1	0	.....	2	6	89
Kings	15	18	4	0	3	.....	5	80
Lassen-Plumas-Modoc	11	11	0	1	.....	.....	7	61
Los Angeles	2,200	2,139	148	23	.....	61	600	79
Marin	40	39	1	0	.....	1	1	97
Mendocino-Lake	19	19	2	0	.....	.....	10	68
Merced	28	23	1	0	.....	5	5	85
Monterey	51	46	0	0	.....	5	2	96
Napa	34	30	0	0	.....	4	3	91
Orange	109	109	7	0	.....	.....	6	95
Placer	30	31	0	1	1	.....	2	93
Riverside	69	64	3	0	.....	5	4	94
Sacramento	143	144	1	2	1	.....	8	95
San Benito	7	5	0	.....	.....	2	3	70
San Bernardino	137	128	4	2	.....	9	5	95
San Diego	258	236	11	6	.....	22	25	88
San Francisco	812	809	27	10	.....	3	536	60
San Joaquin	98	88	1	2	.....	10	20	83
San Luis Obispo	29	26	0	0	.....	3	3	90
San Mateo	58	51	0	4	.....	7	8	88
Santa Barbara	102	103	5	1	1	.....	.....	100
Santa Clara	171	172	8	2	1	.....	74	71
Santa Cruz	30	29	2	0	.....	1	3	90
Shasta	15	11	1	0	.....	4	10	72
Siskiyou	15	20	3	0	5	.....	3	86
Solano	26	23	0	0	.....	3	2	92
Sonoma	54	53	3	0	.....	1	6	90
Stanislaus	40	41	1	0	1	.....	7	85
Tehama	11	11	0	0	.....	.....	4	76
Tulare	38	37	2	0	.....	1	6	87
Ventura	35	33	1	0	.....	2	6	85
Yolo-Colusa-Glenn	26	25	1	2	.....	1	6	82
Yuba-Sutter	15	13	0	0	.....	2	1	94
Totals	5,492	5,320	253	65	13	172	1,431	83
Associate members	6	6						
Retired members	60	59						
Honorary members	9	12						
Total Members	5,567	5,397						

Fourth District—Axcel E. Anderson, M. D., Councilor

San Joaquin	98
Fresno	112
Kings	15
Merced	28
Stanislaus	40
Tulare	38
	<u>331</u>

Fifth District—Alfred L. Phillips, M. D., Councilor

Monterey	51
San Benito	7
San Mateo	58
Santa Clara	171
Santa Cruz	30
	<u>317</u>

Sixth District—Karl L. Schaupp, M. D., Councilor

San Francisco	812
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Seventh District—Oliver D. Hamlin, M. D., Councilor

Alameda	476
Contra Costa	49
	<u>525</u>

Eighth District—C. E. Schoff, M. D., Councilor

Butte	24
Yolo-Colusa-Glenn	26
Lassen-Plumas-Modoc	11
Placer	30
Sacramento	143
Shasta	15
Yuba-Sutter	15
Tehama	11
	<u>275</u>

Ninth District—Henry S. Rogers, M. D., Councilor

Humboldt	30
Marin	40
Mendocino-Lake	19
Napa	34
Siskiyou	15
Solano	26
Sonoma	54
	<u>218</u>

DEATHS

Death claimed sixty-five members. By action of the House of Delegates, deserved tribute will be paid to these departed members during a memorial hour at the first general meeting.

FINANCIAL STATEMENTS
1936

INCOME

Dues	\$54,776.00
Exhibits	3,994.50
Service, medical society	600.00
Interest	28.45
Advertising	27,849.87
Subscriptions	696.15
Reprint sales	461.90
Miscellaneous	30.78
	<u>\$88,473.65</u>

EXPENDITURE

Salaries	\$23,175.84
Committee expense	4,189.79
Legal expense	5,882.64
Travel expense	3,203.43
Library contributions	3,525.90
Rent	3,288.00
Annual meeting	2,942.45
Supplies	1,960.39
Delegates, American Medical Association	1,029.28
Equipment	584.05
Postage, office	409.62
Telephone and telegraph	424.80
Publishing directory	125.00
Taxes	55.64
Interest	32.15
Miscellaneous	1,149.40
Printing, CALIFORNIA AND WESTERN MEDICINE	25,365.51
Advertising commissions	3,953.22
Postage, CALIFORNIA AND WESTERN MEDICINE	1,340.69
Account charged off	849.40
Discounts and collections	238.29
Miscellaneous expense, CALIFORNIA AND WESTERN MEDICINE	140.25
	<u>\$83,858.83</u>
Unexpended balance	4,614.82
	<u>\$88,473.65</u>

BALANCE SHEET
TRUSTEES OF THE CALIFORNIA MEDICAL
ASSOCIATION (A CORPORATION)(At the close of business, December 19, 1936)
San Francisco

ASSETS

Cash		
On deposit:		
Commercial account:		
Bank of America		
N. T. & S. A.	\$ 2,162.27	
Savings accounts:		
The San Francisco		
Bank	\$ 4,634.90	
Crocker First Fed-		
eral Trust Co.	3,949.61	
Bank of America		
N. T. & S. A.	2,879.17	
	<u>11,463.68</u>	\$13,625.95
Investment—United States		
Bonds		
As shown by exhibit		
(Indicated market value		
—\$44,099.30)		39,093.75
Other Assets		
Due from California Medi-		
cal Association	\$31,000.00	
Accrued interest on sav-		
ings account	114.62	
Accrued interest on bonds	91.98	
	<u>31,206.60</u>	
		<u>\$83,926.30</u>

LIABILITIES

NET WORTH:		
Contributed Surplus		
Received from Califor-		
nia Medical Associa-		
tion	75,000.00	
Earned Surplus		
Balance, December 15,		
1935	\$ 7,198.10	
Net income for the pe-		
riod December 15, 1935,		
to December 19, 1936..	1,728.20	
	<u>8,926.30</u>	
		<u>\$83,926.30</u>

Comments:

- (a) Net profit for 1936 was \$5,323.15.
 (b) Advertising sales income was \$27,849.87—a gain of \$4,033.37 over 1935.
 (c) Unpredictable expenses and replacement of equipment entailed the following expenditures:

Kardex—additional unit	\$ 112.00
Typewriters	427.00
Council appeal hearings	342.10
Extra legal expense and attor-	
neys	2,054.64
Dr. Campbell P. Howard	166.75
Special Committees	396.31
Printing Cancer Report	930.00
	<u>\$4,418.80</u>

- (d) Annual meeting profit was \$1,052.25.

(e) The economy measures and operation savings inaugurated in 1935 were continued during 1936. Additional economies were established during the current year. Attention is directed to the income derived from commercial exhibits during the annual meeting. The revenue received paid all of the expenses of an annual meeting, in the sum of \$2,942.45, and produced a net profit of \$1,052.25. The annual budget, approved by the House of Delegates, is strictly conformed with in every item.

The gain of \$5,323.15 for the year is gratifying when all of the Association's action and business is reviewed. It should be remembered that our Association is an active-going organization whose operation involves financial expenditures. These expenditures receive the critical supervision of the Auditing Committee and the Council. Funds are not disbursed without careful review and control of all expenditures.

In considering finances it is germane to direct the attention of all members to the fact, often overlooked or forgotten, that our organization expenses are not greater by reason of the fact that the members of the Council and of standing committees serve without receiving a per diem for their time. This is an important fact, and represents a very sizeable sum of money. Every member of the Council contributes about thirty-five full days of his time, and loses those days from his practice income, in discharging official duties and attending Council meetings.

The members of the Council during 1936 gave 665 days of time to Association business. Had they received a stipend per diem of \$10, Association expenses would have been increased by \$6,650. Our members should be, and I believe they are, grateful for this unselfish contribution on the part of Council members. A similar contribution is made by committee members. These facts constitute an inspiring and unique feature of medical organizations.

COUNTY SOCIETY UNITS

In company with either the president, president-elect, or councilor and, in certain instances, with the speaker, your secretary has again visited and attended a meeting of every county society.

It has been a real privilege and an inspiration to make these visits and to attend county meetings. These visits have accomplished a better understanding, brought about a truer insight of Association activities, and accomplished a cohesive unity of purpose among all constituent units.

Additional Meetings.—Your secretary has attended and addressed meetings of the following bodies:

Parent-Teacher Organizations
American Legion
Kiwanis and Rotary clubs
Western Hospital Association
State Secretaries Conference, Chicago
Woman's Auxiliaries
Postgraduate Conferences
Y. W. C. A., San Francisco
State Traffic Safety Group
Code Commission

In addition to train travel, 8,914 miles were traveled by automobile.

Contacts.—Contacts were made and new contacts were established with the following:

Heads of Departments of State Government
Parent-Teachers' Organization
American Legion
California Hospital Association
Newspaper Editors' Association
Red Cross
State Chamber of Commerce
San Francisco Chamber of Commerce
Junior Chamber of Commerce
United States Public Health Service
Airline Pilots' Association
Associated Press
Nurses' Association
Y. W. C. A.
Code Commission
State Dental Association
Medical Secretaries' Association
California International Exposition
Golden Gate International Exposition
Officers, Hamilton Field
Convention Bureau
American Executives' Association

These contacts afford desirable opportunities to present our activities and policies.

No attempt has been made to keep a record of the many lay inquiries received or of the lay and laymen representatives that have called at the office. Each day brought one or more of these to the office and afforded opportunities, which were embraced, to bring about better understanding and information as to Association purposes and functionings.

ANNUAL MEETING

The report of the Scientific Committee—of which the secretary by by-law provision is chairman—transmits details and recommendations regarding the scientific program. Arrangement provisions are supervised by the secretary in joint labor with local committees. The appraisal can be made that our annual meetings fully repay a member for time and money spent to attend. This is being recognized. Registrations have been steadily increasing each year.

ASSOCIATION ACTIVITIES

Through issues of our official journal, by means of bulletins, monthly letters, and special reports, comment has been made upon all Association activities for the information of members. Specific comment and summary is, therefore, omitted from this report, as it is assumed that the detailed information has been made available, and repetition is not indicated.

ASSOCIATION HEADQUARTERS

It has been repeatedly stated before all county meetings and in correspondence that the office of the Association is the personal headquarters of every member. Its re-

sources are always available whenever a member feels the need of information or assistance. A sustained effort is made to cause it to be in a position to meet all the needs and requirements of our Association. Reference files, an expanding library, and reports on subjects related to medicine and medical service are kept available. Administrative methods are systematized, and detailed records of membership are complete.

The office staff is composed of four individuals. To them, for the Association, and personally, I express a very genuine appreciation for the services rendered during the year, their loyal and willing coöperation, and for their faithful discharge of duties.

CALIFORNIA AND WESTERN MEDICINE

As business manager of the Association's official publication, all business matters have been directed from the central office. These managerial details relate to advertising, exchanges, book reviews, reprints, mailing, and the mechanics of publication. I have endeavored to closely coöperate with the editor, Dr. George H. Kress, to assist him in causing the JOURNAL to be the outstanding medical journal that it is. I desire to express to the editor my appreciation for his generous consideration and helpfulness.

MISCELLANEOUS ACTIVITIES

This office has sought to be of material assistance to all standing and special committees. All office facilities have been made available to every committee. Committee achievements will be reported upon by the chairmen.

SUGGESTIONS

The following suggestions are tendered for Council consideration and recommendation to the House of Delegates:

1. Recreation of certain standing committees and the abolishing of others. Changing conditions have terminated the purposes for which some of these committees were created.
2. The securing of property for a permanent headquarters.
3. The establishment of a packet library reference service.
4. The holding in October of each year of a two-day session for an annual conference of county secretaries and members of standing committees.
5. A campaign for detailed solicitation to establish a permanent endowment fund.
6. Sponsorship for an annual conference of representatives of the three state medical organizations on the Pacific Coast.

CONCLUSION

Your secretary continuously seeks to administer the specific instructions of the House of Delegates, officers, and the Council. Unswerving compliance with and observance of established policies and procedures is ever the rule for administrative action. The faithful discharge of all of the reposed responsibilities of this office has been my constant quest regardless of time, place, or occasion. It is always my desire and effort to render every possible service and assistance, and as expeditiously and efficiently as it is humanly possible to serve. During the year I have been absent from the office and Association work on personal affairs on two occasions, once for three days and once for four days.

Finally, I desire to record a very real appreciation and gratefulness for the many courtesies shown me, for the trust reposed in me, and for the generous assistance rendered by so many officers and members. It is an honor to be privileged to serve this Association and its members. My thanks are sincere.

Respectfully submitted,

Frederick C. Warnshuis, *Secretary.*

REPORT OF THE EDITOR

To the President and the House of Delegates:

The editor's report on papers received, printed, awaiting publication, or declined, is as follows:

(a) *Report on papers of the annual session at Coronado, May 25-28, 1936:*

At last year's annual session a total of 155 papers were read before the general meetings and different sections.

A summary of the disposition of the papers read at last year's annual session is as follows:

Coronado annual session papers published in 1936.....	31
Coronado annual session papers published in 1937.....	20
Coronado annual session papers, read but published elsewhere, declined, or not sent in.....	86
Coronado annual session papers in CALIFORNIA AND WESTERN MEDICINE files still awaiting publication (annual session papers in this April issue to be deducted)	18

Total annual session papers read at Coronado.....155

(b) *Report on all special articles which have been printed in CALIFORNIA AND WESTERN MEDICINE during the period April, 1936 to April, 1937 inclusive.*

Special and original articles which were published in CALIFORNIA AND WESTERN MEDICINE during the past year (April, 1936 to April, 1937 inclusive) are as follows:

Section papers from annual session at Yosemite, 1935....	44
Section papers from annual session at Coronado, 1936....	47
Papers read before general sessions at Coronado, 1936....	4
Lure of Medical History articles.....	12
Papers read before county and other medical societies....	4
Papers accepted from miscellaneous sources (original articles, abstracts of speeches, reprints from other publications, etc.).....	27
Clinical Notes and Case Reports.....	27
Editorials.....	53
Editorial Comment articles.....	26
Bedside Medicine symposia.....	12
Special articles.....	52

Total papers published during past year.....308

(c) *Report on manuscripts in CALIFORNIA AND WESTERN MEDICINE files and awaiting publication in April, 1937, and later issues:*

Unpublished papers from annual session at Coronado*....	18
Unpublished papers read before county and other societies.....	3
Unpublished papers not read before other societies.....	8
Lure of Medical History articles.....	4
Clinical Notes and Case Reports.....	16
Editorial Comment articles.....	1
Bedside Medicine symposia.....	3

Total manuscripts on hand awaiting publication..... 53

(d) *Report on non-annual session papers submitted:*

A total of twenty-nine papers from county societies and other sources, which were submitted for publication in CALIFORNIA AND WESTERN MEDICINE during this past fiscal year (April, 1936 to April, 1937 inclusive) could not be accepted for various and special reasons.

Non-annual session papers submitted, but declined..... 29

During the last year, no innovations in form of the official journal were introduced, with the exception of supplements authorized at our suggestion by the Council, as recorded on page 189 of the March, 1937, issue.

Concerning finances, this subject was discussed in last year's report given on pages 411 and 412 of the issue of May, 1936. As then and there pointed out, the federal postal authorities require that all organizations publishing official journals shall fix a subscription price for members. During the last two years the Council has placed this figure at \$3 per member (one-half the regular subscription price), which, with the advertising income of some \$27,849.87, permits a paper or bookkeeping profit of almost \$5,000. The real cost, therefore, of the official journal to its members is the difference between its total advertising and miscellaneous income and its total cost; a sum which, when divided by 5,500 (the number of California Medical Association members), gives the actual cost of the JOURNAL to each member (less than \$3 per year).

As will at once be seen, there is a distinct advantage in having the JOURNAL departments maintain a somewhat permanent form and a regular place in the magazine, for then readers are enabled to peruse the publication with greater ease and satisfaction. It is possible that some of the usual departments may have little appeal for certain members; however, since tastes differ, and we have this large reading group of 5,500 members, each of whom pays exactly the same amount in support of CALIFORNIA AND WESTERN MEDICINE, it is proper and only fair that effort should be made to cater somewhat to their varying preferences.

* By contrast, last year's report on annual session papers showed forty-five unpublished papers from the previous annual session at Yosemite. With the appearance of the May issue all but five of the accepted Coronado annual session papers will have been printed.

It must also be remembered that CALIFORNIA AND WESTERN MEDICINE is primarily the printed mouthpiece of organized, rather than technical scientific medicine, thus explaining the large and increasing amount of space given to Association activities, and why annual session papers of a technical character are often released for publication in specialty journals. In fact, it may be said that papers which should have an appeal to physicians in general practice have better opportunities for acceptance than those of more limited scope and interest. The latter, when of real worth, can nearly always find acceptance in the publications devoted to the specialties.

Finally, a few words may not be out of place concerning certain phases of the JOURNAL's format. In its report at the Yosemite annual session, the Committee on Publications called attention

to the advantage of having no advertising on the outside front cover, the reasons for this being that it made for greater ease in studying the contents and also added to the attractiveness and dignity of the appearance of our official journal. In our judgment, this procedure should be continued.

The Reference Committee on Reports of Officers and Committees reported:

Committee on Publications

The Reference Committee recommends that the procedure of having no advertising on the outside front cover be continued. And the present high standards laid down for advertising copy be continued.

The Committee recommends adoption.

With the above action of the Yosemite House of Delegates, the editor is in full accord, and would call attention to the fact that an increasing number of state medical society publications are freeing their front cover of advertisements because it is probably true that the greater income of such front-cover advertising is not all real or net (coming as it often does from advertisers who give up a larger amount of inside-page advertising to get a better position in preferred space). The editor is of the opinion that there would be an immediate and heavy protest if the table of contents on the front cover, so easily referred to, were carried over to inside advertising pages, thus creating for all readers an inconvenience soon apparent.

Some comment may also be in order concerning two regular features which find place in single columns on the text page of each issue: The Twenty-Five Years Ago column and the State Board of Medical Examiners department. Concerning the first, it may be stated that, though almost one hundred years have elapsed since our Association was founded, very little attention has been paid to the past history of the Association. This column frequently contains paragraph items to indicate that our colleagues of twenty-five years ago were quite as alert to existing medical problems as we are of the present day. Regarding the State Board of Medical Examiners department, it is the duty of every physician to know somewhat of that Board's problems. The newspaper items, from the ordinary journalistic standpoint, have real value, the printing alone of the sad fate of those who transgress being of the highest educational importance. In fact, it is shocking to note how, in spite of the deplorable penalties to those who, for instance, violate federal and state narcotic laws, such offenders continue to present themselves.

In connection with these two departments it must also be remembered that the front and back advertising folios or signatures of each issue must be printed a week or so in advance of the pages of text, and that these folios or signatures, for greater ease in printing and lesser cost, must be in multiples of four. That necessitates the use of "fillers," which advertisers welcome, as they make their pages more attractive. Without the Twenty-Five Years Ago and State Board copy for preferential filler use, it would be necessary to use items from other medical journals, of lesser interest and value to California physicians. Owing, then, to recent discussion as to possible economies in printing, the above explanation is given. From the editor's experience, no printing expense would be eliminated by doing away with these two columns, of real interest to so many members.

In similar manner, if space permitted, the merits of all departments of the official journal could be discussed.

The editor wishes to thank the many members who have coöperated, and whose contributions have made possible the issuance of a state journal that, it is hoped, is a credit to the California Medical Association and its members.

Respectfully submitted,
George H. Kress, *Editor*.

REPORT OF THE LEGAL DEPARTMENT

To the President and the House of Delegates:

During the past year a number of problems falling within the field of jurisprudence have come before the Association, and many are before it at the present time. The legal department has at all times endeavored to assist and aid your Council and Executive Committee with respect to those problems of a legal nature which have faced and now face the medical profession.

A brief résumé of the more important phases of the past year's work of the legal department will be undertaken in this report.

Disciplinary Appeals to the Judicial Council of the American Medical Association.—After the adjournment of the House of Delegates at Coronado May 27, 1936, several members of the Association, who had previously been disciplined by their component county societies and whose appeals to the Council of the California Medical Association had resulted in an affirmation by the Council of the disciplinary measures taken by the component county societies, appealed to the Judicial Council of the American Medical Association. Under the rules of procedure governing appeals to the American Medical Association's Judicial Council, it became necessary for the California Medical Association, through its Council, to prepare and file written briefs. The legal department gave its assistance and a great deal of its time to the Council in this matter, in order to aid the Council in matters of procedure.

Expert Witnesses.—It is an open question in California whether a physician who, voluntarily or in obedience to a subpoena, gives expert opinion testimony in a legal proceeding without having first secured compensation for his services in furnishing such opinion testimony, may subsequently recover from the party calling him the reasonable value of his services. In many states a physician who so testifies without having first been paid can recover nothing if the party calling him refuses to pay for his services. At the direction of the Council, this department undertook to represent a member of the Association who had refused to give opinion evidence unless first paid therefor. It was thought at the time that this proceeding might become a test case; however, the litigant who had insisted upon asking the physician questions calling for opinion evidence did not press the matter. Subsequently, and also at the direction of the Council, this department prepared a legislative bill for the purpose of adding to the statutes of this State a provision requiring litigants seeking opinion evidence from a physician (or other expert) to pay the reasonable value of the expert's services.

The proposed bill prepared by this department was approved by the Council and has been introduced at the present session of the Legislature by Senator McGovern, as Senate Bill 446. This bill is of great importance to the medical profession, and should be carefully considered by all members of the Association.

Corporate Practice.—This department's report for the year 1935 (CALIFORNIA AND WESTERN MEDICINE, May, 1936, page 412), summarized the decision in *Pacific Employers Insurance Co. vs. Insurance Commissioner*, which firmly established the California law to be that a corporation cannot practice medicine or surgery. In June, 1936, the District Court of Appeal for the Second Appellate District decided the case of *Benjamin Franklin Life Assurance Co. vs. Insurance Commissioner*. This case extended the rule that a corporation cannot practice medicine to include indirect corporate practice; the court held that an insurance company could not, through the medium of insurance, engage in the sale of medical services, regardless of the methods and forms used. The House of Delegates at its last annual session adopted a resolution directing the Council to prepare, with the assistance of

the legal department, a letter setting forth the legal and ethical aspects of the corporate practice of medicine, and further directing that the letter be sent to all members of the Association.

In accordance with the House of Delegates' resolution, this department prepared an opinion, which was submitted to the Council, dealing with the legal aspects of corporate practice.

California Code Commission: Business and Professions Code.—Several years ago the California Legislature created the California Code Commission. It is the Commission's duty to correlate and restate, without changing the substantive law, all of the legislative acts enacted by the California Legislature since its first session in 1850, which have not been repealed and which are, therefore, in full force and effect. Each general field of legislation has been given a title, and all of the statutes relating to that particular field are being collected and placed in codes bearing the title of the field concerned. We have, for example, the Motor Vehicle Code, Agricultural Code, Insurance Code, and School Code.

During the past year the California Code Commission has been engaged in the preparation of a Business and Professions Code. This code is to include all statutes relating to the various professions and businesses within the State. One portion of the Code will contain all statutes relating to the practice of medicine, including, of course, the Medical Practice Act. This department has kept in constant touch with the California Code Commission and with the officers of the Association, the members of the Board of Medical Examiners; and their counsel, Deputy Attorney-General Browne, and your general counsel and his assistant have spent several full days with Mr. Arthur McHenry, Statute Reviser for the Code Commission. Each draft of the Business and Professions Code has been carefully reviewed by this department, and in several instances suggestions have been made to the California Code Commission and adopted by it which, in our opinion, materially strengthen the legal position of the medical profession.

Physicians' Handbook.—The Council has directed your general counsel, secretary-treasurer, and editor to prepare a physicians' handbook containing, in summarized form, the various principles of law and statutes governing the practice of medicine and surgery. A tentative outline of the subjects to be included in the handbook has been prepared by this department and the secretary-treasurer. Further progress is being made as rapidly as possible.

Medical Jurisprudence Column.—Several months ago the Council established a department in CALIFORNIA AND WESTERN MEDICINE, entitled "Medical Jurisprudence," and each month since its creation by the Council, this department has appeared in CALIFORNIA AND WESTERN MEDICINE. Your general counsel has prepared each month, for this department, articles upon medico-legal problems and other legal matters of interest to the medical profession.

Hospital Service Insurance.—During the past year the Council has given a great deal of its time to the subject of hospital service insurance. A committee of the Council has devoted an immense amount of time to the study of this subject. The legal department has endeavored to do its part in aiding and assisting the Council and the Committee on Hospital and/or Medical Insurance. Much time and study has been given by this department to the subject of indemnity riders on hospital insurance contracts to provide for x-ray and clinical pathologic services. At the direction of the Council this department gave its aid and assistance to the Associated Hospital Service of Southern California in its endeavor to secure a permit from the Insurance Commissioner under the Nonprofit Hospital Service Act of 1935. This department has also worked with the Insurance Commissioner's office and the representatives of the Association of California Hospitals in the preparation of necessary amendments to the Nonprofit Hospital Service Act. At the present time the Legislature has before it Assembly Bill 1132, which is a semifinal draft of the amendments formulated as the result of conferences between representatives of the Insurance Commissioner, the Association of California Hospitals, and this department. The legal department is now de-

voting considerable study to further amendments which have been submitted by the hospital group.

Medical Service Insurance.—Pursuant to requests from the Committee on Medical and/or Hospital Insurance, and at the direction of the Council, this department has assisted the committee in the preparation of a medical service bill. Considerable research work has been done in order that the Association may be fully informed with respect to the constitutional and statutory problems involved in medical service insurance, and in order that the bill may not run afoul certain constitutional principles. At the present time the Association's medical service bill is before the Legislature as Senate Bill 605. This department is also assisting the committee with respect to proposed amendments to the bill.

Miscellaneous.—During the year, opinions of considerable interest have been requested and furnished, dealing with such subjects as the California Unemployment Reserves Act, the Federal Social Security Act, the effect of city ordinances imposing license taxes on physicians, the legal and ethical aspects of certain types of group practice, the scope and legality of various hospital insurance policies, the relative protection afforded members by various physicians' liability insurance policies, and the duties of an employee under copyright law with respect to material compiled in the course of employment. A bill (suggested by the San Diego County Medical Society) to amend the Medical Practice Act so that advertising that services will be performed for fixed fees shall be unprofessional conduct has been prepared. The usual examination of all bills introduced in the Legislature relating to the medical profession has been made, and amendments to a number of the bills have been drafted. Among these, bills pertaining to county hospitals, and the private records of physicians are of the first importance.

Attendance at meetings of the Council, Executive Committee, and other standing committees has obtained throughout the year. In addition, your general counsel has been present at meetings of the Committee of Five, and assisted it in various legal matters of importance to the Association.

Respectfully submitted,

Hartley F. Peart, *General Counsel.*

II

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties

To the President and the House of Delegates:

All county organizations have been visited several times and found to be active and highly interested in affairs of the day. Uniformity in the ranks is everywhere noted, and regular medicine and surgery can well be proud of the defense that is everywhere seen and ready to solve our economic and professional problems. State Secretary Warnshuis and President Palette joined me in visiting all of the societies of the First District. Their presence was welcome, and their coming again is anticipated.

Situations have not been so tense in this district as experienced by some of the metropolitan areas, but with a high percentage of membership on any county roster a more satisfactory solution of questions can be expected than when medical men are divided. Orange, Riverside, San Bernardino, and Imperial counties have all the eligible and desirable medical men on their roll.

Opposition to the opening of county hospitals to all residents is generally opposed, and should be prevented if possible, as it is one of the entering wedges to the regimentation of the medical men.

Postgraduate meetings have been held in Orange, Riverside, and San Bernardino counties, and where the clinical picture was carried along with the case presentation it proved to be more interesting to the men than where a paper was read.

This year the second session of county secretaries with the state officers was held in San Francisco. The secretaries of the First District in attendance, as well as those

from the other counties, are enthusiastic about the gatherings and are desirous of their continuance.

Every society "went into politics" this year. Our State Medical Legislative Committee, therefore, will find that our lawmakers have been "talked to" before coming to Sacramento, and will know something about what they are expected to do to keep peace with the boys at home.

Respectfully submitted,

Calvert L. Emmons, *Councilor,*
First District.

SECOND COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

During the past year there has been a very satisfactory increase in membership, which now stands at 2,378.

Our political strength is being continually augmented, as our organization is improved. The coöperation of the Public Health League has been invaluable here.

Our radio broadcasting is attracting increasing attention. We have recently been requested by the local Parent-Teachers' Association to supply them with our programs in advance.

Much attention has been devoted to the development among our members of a speakers' bureau. Quite a number of them have taken a course of instruction in public speaking, and an organization has been formed which meets regularly for further development along these lines. We are having numerous calls for appointments for this department.

The social activities of the Association have done much to increase interest and good fellowship. These have included bridge tournaments and a chess tournament. A hobby show was held early this year at which extensive exhibits of a very high order and great variety were shown. So much interest was aroused that it is planned to repeat it on a larger scale. At the time of writing, arrangements have been completed for an amateur night, with entertainment entirely supplied by members, each branch of the Association being responsible for one number on the program. These activities have been made possible because of our commodious quarters, and are in addition to the scientific meetings, of which there is an average of twenty a month, a dinner being served for the members before the meetings.

Through the generosity of the Southern California Medical Golf Association, we now have a grand piano in the auditorium. A loudspeaker system has also been installed and is available for all meetings.

Not the least of our growth has been in our library. Many new volumes have been added, and additional stacks for 60,000 volumes have been installed.

We feel that the prospects for continued healthy growth are most promising.

Respectfully submitted,

Carl R. Howson, *Councilor,*
Second District.

THIRD COUNCILOR DISTRICT

Kern, San Luis Obispo, Santa Barbara, and Ventura Counties

To the President and the House of Delegates:

All the component county societies have taken an active interest in the question of hospital insurance. San Luis Obispo, Santa Barbara, and Ventura County Societies met with the Alameda Hospital Group, in the hope that some arrangement might be made to furnish hospital insurance for their counties. It was found, however, that insurance through the Alameda group was not possible at this time. The Santa Barbara Society's Insurance Committee is in close contact with the development of an insurance plan in Los Angeles, and it is hoped that some approved form of hospital insurance will eventually be available. Kern County has negotiated with the Intercoast group at Sacramento, but had not definitely accepted their plan at the time of writing this report. There is no question of the success of hospital insurance in the Third District, once a suitable form is made available. The hospital situation in Kern County is still far from

settled. The report of progress in combating this intolerable condition is omitted, as it appears in the report of the legal department.

It is encouraging to note that influential members of the societies who have never before taken any particular interest in economics are now becoming active in meeting the question of insurance, and through this contact are appreciating for the first time the work of the State Association in protecting the public as well as the medical profession.

Respectfully submitted,

Henry J. Ullmann, *Councilor,*
Third District.

FOURTH COUNCILOR DISTRICT

Fresno, Madera, Kings, Tulare, Merced, Mono, Mariposa, Inyo, Calaveras, San Joaquin, Tuolumne, and Stanislaus Counties

To the President and the House of Delegates:

The councilor has tried to serve the district and the California Medical Association by a sustained effort in reporting developments on such important matters as the proposed voluntary health insurance legislation, and has attempted to ascertain, so far as possible, what action the membership of the district desired the Council to take on these matters.

To help promote public good will and better understanding by the laity of the ideals and aims of our profession, publicity, as sponsored by the Fresno County Society, has been suggested to other county societies. The Public Health hour service idea, advanced by our secretary, Dr. F. C. Warnshuis, has been endorsed as of probable great value in promoting public favor. The use of the radio and other means of public education on medical problems and activities has been advocated.

The membership has been frequently reminded of the necessity for continuous interest in candidates for public office and elections, and that eternal vigilance may help prevent legislation disastrous to public health, and further proper functioning of medical service.

Hospital insurance, as endorsed by the California Medical Association Council, has been urged as a possible answer to the growing demand for free hospital care at county hospitals. Considerable progress has been made in the sale of such insurance in the district.

The advantages and desirability of postgraduate conferences, now available, have been explained.

The Woman's Auxiliary activities have been commended and their extension urged. More such organizations have been recommended, and activities to this end commenced.

An encouraging *esprit de corps* is manifest throughout the district, and full coöperation with the California Medical Association policies and activities is readily given.

Respectfully submitted,

A. E. Anderson, *Councilor,*
Fourth District.

FIFTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties

To the President and the House of Delegates:

A variety of important activities have occupied the attention of the county societies of the Fifth Councilor District during the past year. Some of the most important have been attempts to raise the ethical standards of lodge and panel practice, coöperation with the Red Cross in a program of tuberculin testing in the schools, and participation with the authorities in reorganizing public health, county welfare and county hospital administration. Work along these lines should be of benefit to the communities involved and to organized medicine.

Better scientific programs, in some instances, have resulted from these efforts of the Society officers.

Each county society in the district, where regular meetings are held, has been visited by me at least twice during the year. One Council meeting was not attended because of illness.

Respectfully submitted,

Alfred L. Phillips, *Councilor,*
Fifth District.

SIXTH COUNCILOR DISTRICT

San Francisco County

To the President and the House of Delegates:

During the past year, as in the preceding four or five, the interest of the members has been largely centered on health and hospital insurance, on the periodic payment basis.

In some districts of the State, members have felt that fear among physicians has been the inciting factor in the development of plans for the provision of such service, but in our district we find marked evidence to the contrary.

Our committees have had many meetings on this subject with many groups, among which are the Municipal Employees' Association of San Francisco, numbering over 14,000; the State Employees' Association, numbering many thousands; branches of Credit Unions; and a number of private business concerns which employ large groups. All of these insist that unless the medical profession provides means through which insurance can be secured, they (the various groups) will support legislation to provide it.

In San Francisco a charter amendment has been proposed which, if passed, will make payroll deduction for health service compulsory among the municipal employees. It has fallen upon the members of this district to see that proper provision is made in this amendment for safeguarding the interest of the public as well as that of the physician. In this we feel that we have been reasonably successful. This measure of success, however, did not come easily. In fact, it was made possible only by the aid of the hospitals, the nurses, the dentists, the retail druggists, retail merchants and labor, as well as the very loyal support of individual physicians and groups of physicians.

Real progress has been made in the matter of hospital insurance, and no doubt before you read this, such a type of insurance will be available to employed groups in San Francisco, through the Insurance Association of Approved Hospitals (Alameda County Plan), which has kindly consented to enter San Francisco upon the invitation of the local County Medical Society.

We look hopefully toward the future, but our work has only just begun.

Respectfully submitted,

Karl L. Schaupp, *Councilor,*
Sixth District.

SEVENTH COUNCILOR DISTRICT

Alameda and Contra Costa Counties

To the President and the House of Delegates:

The most important accomplishment of the Seventh District, comprising Alameda and Contra Costa counties, has been the completion during the year just past of the Alameda County Medical Association's hospital plan. In conjunction with the approved hospitals of the East Bay area a mutual insurance company has been organized, and this is operated by the Medical Association and the hospitals jointly. Policies, effective since November 16, 1936, and covering a generous hospital service, are being sold at present to gainfully employed groups only.

Both Alameda and Contra Costa counties hold regular, well-planned, monthly meetings except during the summer months, and both county societies show an increase in membership during the past year.

Alameda County Medical Association has recently revised its Constitution and By-Laws increasing the Association's Council from nine to twelve members, and increasing the term of office of each from one to three years. Provision has been made for continuous representation of the rural parts of the county, as well as for the cities of Alameda and Berkeley.

Respectfully submitted,

O. D. Hamlin, *Councilor,*
Seventh District.

EIGHTH COUNCILOR DISTRICT

Alpine, Amador, Butte, Colusa, El Dorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo, and Yuba Counties

To the President and the House of Delegates:

The past year has been rather a quiet one in the activities of the medical societies in the Eighth District. There have been several local problems which have been ironed out to the satisfaction of the Society members.

The Intercoast Hospitalization Insurance Association has extended activities to several of the northern counties, and their hospital insurance plan has met with the approval of the various county societies and has been a most excellent step forward in hospitalization economics.

During the week of October 8 to 11, President Pallette, President-Elect Morrow, Secretary Warnshuis, and the Councilor visited several of the societies in this district. The meetings were well attended and the officers were very enthusiastically received. Much interest was expressed relative to recent court decisions that have been rendered relating to the healing art and their encroachment upon the field of medicine. The stress of a legislative year was impressed upon the members, and they were cautioned to be alert in all matters pertaining to hospital and medical economics.

The Secretaries' Conference was well attended, considering the climatic conditions which prevented many of the far northern societies from attending.

The memberships in the societies are being kept up, and scientific and economical problems of medicine are keenly observed.

Respectfully submitted,
C. E. Schoff, *Councilor,*
Eighth District.

NINTH COUNCILOR DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties

To the President and the House of Delegates:

A brief report of the medical societies' activities in the Ninth Councilor District during the year 1935 is submitted: During the past year, since the submission of the pre-convention report for 1935, I have made councilor visits to all the county medical societies in this district, and to most of the societies repeated visits have been made in order to inform them of the work of the Council and the activities of organized medicine in California.

Respectfully submitted,
Henry S. Rogers, *Councilor,*
Ninth District.

III**REPORTS OF COUNCILORS-AT-LARGE***To the President and the House of Delegates:*

As councilor-at-large my duties have principally been those of chairman of Committee on Legislation and Public Policy. I have attended meetings throughout the North, have had the honor of serving on a committee recodifying the Medical Practice Act, and on another committee, to write the Medical Service Act, and assisted in the formulation of the Hospital Service Act (all these are now before the Legislature), talked on the subject of medical legislation at the secretaries' and officers' conference in San Francisco, held Legislative Committee meetings with keymen in Los Angeles and San Francisco, and addressed, by invitation, the San Francisco County Medical Society on the subject of legislation.

As this is written, the legislators are beginning to gather at the Capitol to start the study of 3,879 bills. About 7 per cent of these bills are ones in which we have an interest. From my acquaintance with the holdover legislators and with the new ones I have just met, I am inclined to the opinion that this Legislature will be one which will uphold standards and qualifications in medical practice. It, however, appears to be a more social-minded group than heretofore, and I predict a strong and possibly successful fight will be waged by groups among them

to open up county hospitals to all, regardless of ability to pay.

In this report, may I thank the alert members of the county society legislative committees who have contacted their legislators and told them Medicine's story. It has been most helpful to us whose duty it is to carry on at the front.

Respectfully submitted,
J. B. Harris, *Councilor-at-Large.*

To the President and the House of Delegates:

It is my general observation that there are far more members interested in and familiar with the work and value of the California Medical Association than there were a few years ago.

This interest is stimulated, more than by any other factor, by the activities of the Presidents and the Secretary, who have, at no small sacrifice, made personal contact with so many members in their home neighborhoods.

Respectfully submitted,
Morton R. Gibbons, *Councilor-at-Large.*

To the President and the House of Delegates:

During the past year most of my time, as a councilor-at-large, has been spent acquainting the members of the San Diego County Medical Society with developments in hospital insurance and medical service associations. Our society is almost unanimously in favor of hospital insurance, and I believe it will favor any type of health insurance, provided it is sponsored by the California Medical Association.

The inertia within the ranks of the local society is fading away, and the individual members are much more interested in medical economics than they were.

I believe the visits of our new state secretary, Doctor Warnshuis, and the annual secretaries' conference are creating very beneficial effects.

Respectfully submitted,
C. O. Tanner, *Councilor-at-Large.*

To the President and the House of Delegates:

During the past year we have contacted many members in the southern counties. They have shown particular interest in the question of hospitalization on a periodic payment plan. The bill that is now in the Legislature will undoubtedly pass, and will enable the hospitals to sell that sort of insurance.

There are a number of other problems affecting the profession that will require more coöperation from all our members.

Respectfully submitted,
W. H. Kiger, *Councilor-at-Large.*

To the President and the House of Delegates:

During the year I have attended all Council meetings and have served as a member of the Auditing Committee and as chairman of the Special Committee, created by the Council for the study and formulation of plans for voluntary health and hospital insurance. This has necessitated considerable work within and without the membership of the Association, and I am impressed with the fact of a growing trend in the creation of various instrumentalities for providing health insurance.

My experience during the year as councilor-at-large leads me to stress the importance of this tendency and study by the California Medical Association of the means by which its development can be kept within the hands of the profession.

Respectfully submitted,
T. Henshaw Kelly, *Councilor-at-Large.*

To the President and the House of Delegates:

As councilor-at-large I have missed but one meeting of the Board during the past year, and right or wrong, alone or with concurring voices, have never hesitated to express my opinion, and upon occasion fight for any point that affected the welfare of Medicine.

Respectfully submitted,
Harry H. Wilson, *Councilor-at-Large.*

IV

REPORTS OF STANDING COMMITTEES*

COMMITTEE ON ASSOCIATED SOCIETIES AND
TECHNICAL GROUPS

Executive Group

William J. Kerr, Chairman, 1938
John V. Barrow, 1937 W. H. Geistweit, 1939

To the President and the House of Delegates:

The past year your committee has served in an advisory capacity only to the Woman's Auxiliary. Doctor Barrow has been active, and I am quoting from his report. "During the past year I have kept in touch with the Woman's Auxiliary and have been a quiet advisor. I have advised continuous work in health education through the Auxiliaries, which, to my mind, is the finest *entrée* of the medical profession to lay groups. I have urged others to contribute, and have myself contributed to lectures for laymen in service clubs of the city. I would advise the chairman of this committee to deputize a certain number of medical men, whose specific business it shall be to present things of medical interest to lay groups."

I have not been able to secure a report from one of our members.

In line with the suggestion of Doctor Barrow, it would seem that the State Medical Association should appoint representatives in each county to speak on public relations, or have committees of the county societies working with our committee and the Woman's Auxiliary. It should be called to the attention of the State Medical Association that the antivivisectionists have an initiative measure ready for the next general election to prevent all laboratories from securing any experimental animals from pounds or other private sources. It may be necessary to have the help of all possible agencies and groups to combat this measure, or to introduce an initiative measure which will really protect the public, agricultural interests, and the medical profession from those who are acting against the best interests of the State.

Respectfully submitted,

William J. Kerr, *Chairman*.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Executive Group

Fred B. Clarke, Chairman, 1938
Benjamin W. Black, 1937 W. R. P. Clark, 1939

To the President and the House of Delegates:

Your standing Committee on Health and Public Instruction respectfully reports that its major activities have been evidenced through the Department of Public Relations.

Your committee directs attention to the publicity that is concerned with the venereal disease educational program inspired by the United States Public Health Service. We feel that this program rightly belongs under the administrative guidance of the State Board of Health.

We recommend that the House of Delegates endorse the action of the Council upon this subject. We recommend that every member and group cause their activities to be in conformity with the plans outlined by the Board of Health, and that unity of action be not diverted by independent or disassociated efforts which are bound to cause confusion and reduplication of work and lessen the effectiveness of the program of the Board of Health. Your committee records its confidence in the Board of Health and fully believes that that Board will ever be mindful of the interests of the private practitioner.

Your committee would further recommend that the Association's secretary confer with the officers of the Woman's Auxiliary for the purpose of inspiring a definite yearly program of public health education under the sponsorship of the several branches of the State Auxiliary.

Your committee has been particularly interested in the development of a speakers' bureau in each and every

county unit, to the end that the public may be better informed in matters relating to sickness and health.

Some county units are doing exceedingly fine work in this respect, and it is urged that during this next year this work will be extended.

Respectfully submitted,

Fred B. Clarke, *Chairman*.

COMMITTEE ON HISTORY AND OBITUARIES

Executive Group

Frank R. Makinson, Chairman, 1938
George D. Lyman, 1937 J. Marion Read, 1939
The Secretary, ex officio The Editor, ex officio

To the President and the House of Delegates:

While no formal meeting of the committee was held during the year, there were conferences and correspondence between committee members.

An effort has been made through the columns of CALIFORNIA AND WESTERN MEDICINE, by President Pallette and the committee, to have county historians appointed. Such a step is indispensable to the greatest degree of success in collecting historical material.

A considerable amount of work has been done on the history during the year, yet only the surface has been scratched.

It is my opinion and recommendation that a full-time worker should be employed by the Council to do the research work on the history before an increased period of time is permitted to circumvent a high degree of success. It is impossible for a man busy with a practice to do the time-consuming detail research work necessary to obtain the information concerning the early history of the Association, yet its value, its tradition and history of Medicine in the State highly justify it.

Following is a list of members of the California Medical Association whose deaths occurred during the last year:

IN MEMORIAM

Allen, John, October 4, 1936, Raymond.
Ames, Elwin Witt, April 6, 1936, Los Angeles.
Arnold, Mott Hutton, December 9, 1936, San Diego.
Ball, Jau Don, November 25, 1936, San Francisco.
Baumeister, Edward Emery, May 3, 1936, San Francisco.
Beard, John Lyman, November 9, 1936, Martinez.
Beattie, Hugh, September 18, 1936, Elk Grove.
Beckett, Wesley Wilbur, June 3, 1936, Los Angeles.
Bigby, Margaret H., September 26, 1936, Downey.
Bixby, Edward Marcellus, April 24, 1936, San Francisco.
Bonta, Maurice Buford, January 5, 1936, Los Angeles.
Brendel, Frank Philip, May 24, 1936, Sacramento.
Brewer, Lambert Cleveland, May 11, 1936, Los Angeles.
Burg, Beatrice Victoria, April 4, 1936, Oakland.
Buskirk, William H., August 7, 1936, Los Angeles.
Chase, Raymond E., July 14, 1936, Glendale.
Chidester, Walter Clifford, April 21, 1936, San Mateo.
Collings, Harry Andrews, March 8, 1936, Susanville.
Doig, Robert L., May 9, 1936, San Diego.
Dougherty, Edwin E., July 17, 1936, Los Angeles.
Duffield, William, September 9, 1936, Los Angeles.
Fisher, Charles Albert, June 20, 1936, Los Angeles.
Gatliff, William Walker, May 12, 1936, Butte City.
Golding, Daniel G., April 28, 1936, Santa Monica.
Graham, John Alexander, January 1, 1936, Barstow.
Goodenow, Norman H., October 14, 1936, Monrovia.
Harc, George Andrew, April 4, 1936, Fresno.
Harrison, Fred, April 24, 1936, Gridley.
Hawley, Max Charles, January 1, 1936, Agnew.
Heald, Alfred Henry, March 12, 1936, San Mateo.
Hemken, Louisa, November 20, 1936, Los Angeles.
Hicks, John R., August 1, 1936, Tulare.
Hieronymus, Arthur, December 5, 1936, Alameda.
Hubble, J. Edgar, July 30, 1936, Pomona.
Kendall, Oscar J., November 18, 1936, San Diego.
Kirkpatrick, John L., May 17, 1936, Los Angeles.
Lackay, Howard Julian, May 15, 1936, Oakland.
Lagan, Edward, May 17, 1936, San Francisco.
Langnecker, Harry Leslie, September 23, 1936, San Francisco.
Latta, Samuel E., June 13, 1936, Stockton.
Liliencrantz, August, October 9, 1936, Oakland.
Lund, Charles W., November 4, 1936, Willows.
Macleish, Archibald Campbell, May 4, 1936, Los Angeles.
March, William Bright, June 23, 1936, Burson.
Matsumura, Kiyoshi, January 5, 1936, San Francisco.
Merrill, Edward Roscoe, February 13, 1936, Santa Barbara.
Miner, Lucien L., June 5, 1936, Los Angeles.
Moore, Thomas Verner, June 6, 1936, San Jose.

* Members of standing committees are urged to meet during the annual session and organize for the coming year, and to hold at least one regular meeting of their respective committee during the annual session.

Newman, Henry Parker, September 23, 1936, San Diego.
 Noggle, George Elliott, April 8, 1936, Chino.
 Oatman, Homer Clifton, January 1, 1936, San Diego.
 O'Donnell, Earl William, February 16, 1936, Los Angeles.
 Offield, Archie Leonard, September 17, 1936, Burlingame.
 Rathbun, William T., January 2, 1936, Colusa.
 Richter, Clemens Max, May 19, 1936, San Francisco.
 Rigdon, Rufus Lee, January 21, 1936, San Francisco.
 Roath, Clinton, January 26, 1936, Los Angeles.
 Rosoff, James A., January 24, 1936, Compton.
 Rothschild, Max, July 11, 1936, San Francisco.
 Striegel, Raymond John, February 26, 1936, Long Beach.
 Thieme, Derk Anthony I., October 5, 1936, Los Angeles.
 Vowinkel, Ferdinand Wilhelm, February 24, 1936, San Francisco.
 Wheeler, Ira Abbey, January 2, 1936, Colfax.
 Witherbee, Orville O., December 24, 1936, Los Angeles.
 Woods, Donald Kendrick, December 10, 1936, San Diego.
 Respectfully submitted,
 Frank R. Makinson, *Chairman.*

COMMITTEE ON HOSPITALS, DISPENSARIES CLINICS

Executive Group

Daniel Crosby, Chairman, 1939
 Karl L. Schaupp, 1937 John C. Ruddock, 1938

To the President and the House of Delegates:

In the matter of report of the Committee on Hospitals, Dispensaries and Clinics, please be advised that, inasmuch as all questions of this sort have been handled by the Public Relations Committee, this committee has had no meeting and, therefore, has no report to make at this time.

Respectfully submitted,
 Daniel Crosby, *Chairman.*

COMMITTEE ON INDUSTRIAL PRACTICE

Executive Group

Morton R. Gibbons, Chairman, 1938
 Harry E. Zaiser, 1937 *Mott H. Arnold, 1939

To the President and the House of Delegates:

No question concerning this subject has been brought to the attention of the committee in the past years; whether or not no one has considered inquiry or complaint worth while is not known. It is inferred that the practice of industrial medicine is running smoothly.

Respectfully submitted,
 Morton R. Gibbons, *Chairman.*

COMMITTEE ON MEDICAL DEFENSE

Executive Group

George G. Reinle, Chairman, 1938
 John P. Nuttall, 1937 Fred R. DeLappe, 1939

To the President and the House of Delegates:

The Medical Defense Committee begs to advise that during the past year nothing has been referred to it; therefore, it has no report to make, although advised that the premiums for malpractice insurance have been increased.

Respectfully submitted,
 George G. Reinle, *Chairman.*

COMMITTEE ON MEDICAL ECONOMICS

Executive Group

John H. Graves, Chairman, 1938
 Willard Stone, 1937 William R. Molony, Sr., 1939

To the President and the House of Delegates:

Correspondence between the members of the committee has been maintained, and the chairman of the committee has attended the meetings of the Committee on Public Relations.

No independent action by this committee has been inaugurated during the past twelve months in view of the extensive program outlined by the Committee on Public Relations, to which this committee gives its full support.

Respectfully submitted,
 John H. Graves, *Chairman.*

* Deceased, December 9, 1936.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Executive Group

Loren R. Chandler, Chairman, 1939
 John B. Doyle, 1937 B. O. Raulston, 1938

To the President and the House of Delegates:

Your Committee on Medical Education and Medical Institutions has held no meetings during the year. The activities of the four medical schools in California are well known to this society. Your committee has cooperated with the deans of these schools and the Society's Committee on Postgraduate Education at informal discussions, but there have been no formal meetings of this committee.

Respectfully submitted,
 Loren R. Chandler, *Chairman.*

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

Executive Group

E. Vincent Askey, Chairman, 1938
 G. Dan Delprat, 1937 Dewey R. Powell, 1938
 The Secretary, ex officio

To the President and the House of Delegates:

The Committee on Membership and Organization has held no official meetings during the year.

Due to efficiency in our component county association set-ups, specific expansive campaigns for membership have not been necessary. A steady, healthy increase of membership has been apparent.

In the hands of each county society secretary has rested the responsibility of seeing that those eligible physicians of his county are informed of the needs and advantages of membership in our Association. Our state secretary, Dr. F. C. Warnshuis, has placed at the disposal of these county secretaries all the facilities and help necessary in carrying out their plans.

At the yearly county meeting of secretaries at San Francisco, the duties and responsibilities regarding membership were discussed, and renewed effort in urging every qualified physician to join our ranks was pledged. The larger centers of population still lag in the ratio of the number of members in relation to eligible physicians, as compared with the smaller localities. Some counties have 100 per cent representation; others approach closely this percentage.

The importance of keeping the California Medical Association the actual representative of more than a majority of all the licensed doctors of medicine should be remembered.

To achieve the utmost value from our organization it must remain the spokesman and wheelhorse of the medical profession. For that reason every doctor of medicine who meets our requirements, and is an ethical practitioner, should be given the opportunity of becoming a member of the medical society of his county, and thereby of the California Medical Association and the American Medical Association.

As need arises, your committee stands ready to initiate and carry through such plans and programs as are deemed wise and best.

Respectfully submitted,
 E. Vincent Askey, *Chairman.*

COMMITTEE ON POSTGRADUATE ACTIVITIES

Executive Group

Clarence G. Toland, Chairman, 1938
 John C. Ruddock, 1937 F. F. Gundrum, 1939
 The Secretary, ex officio

To the President and the House of Delegates:

During the past year your committee has been active and has caused to be given, in various communities throughout the State, conferences available to the membership of the California Medical Association residing in these various localities.

On February 6, 1937, a meeting of the Committee on Postgraduate Activities was held in San Francisco in the Sir Francis Drake Hotel. An invitation was extended by Dr. Clarence G. Toland, Chairman of the Committee,

to the deans of the medical schools of the University of California, Stanford University, University of Southern California and the College of Medical Evangelists, and to Mr. W. F. Higby of the California Tuberculosis and Heart Association and Dr. Charles A. Dukes, Chairman of the Committee on Public Relations of the California Medical Association, to confer with the committee and offer suggestions as to the best method of presenting postgraduate programs during the coming year. Those present were: Dr. Clarence G. Toland; Dr. John C. Ruddock; Dr. Charles A. Dukes; Dr. Loren R. Chandler, Dean of the Stanford University Medical School; Dr. R. Langley Porter, Dean of the University of California Medical School; Dr. Paul S. McKibben, Dean of the University of Southern California Medical School; and Mr. W. F. Higby of the California Tuberculosis and Heart Association.

A complete discussion of the problem of postgraduate activities and the method of making available to the membership of the California Medical Association the latest advances of medical science was had. A uniform and coöperative program was agreed upon by the various universities and units in order to make this proposed activity successful.

It has been realized and evidenced in the past that physicians who practice and live in the metropolitan centers have available to them the refresher and review classes conducted by the medical schools. These refresher and review classes offer the most successful postgraduate instruction today. However, it is impossible for physicians not in the immediate vicinity of the universities offering these classes to take advantage of them. Because of the demand made upon these practitioners by their practice they are unable to absent themselves from their communities, except for short periods of time; nor are they more able to follow the current literature thoroughly; and, further, libraries are not easily available to them.

The committee, when organized, was given the task of bringing to the physicians of California so situated the advantage of the opportunities of those physicians who were in metropolitan districts, and the committee now proposes a certain definite program for postgraduate activities conducted by the California Medical Association.

The committee feels that the proposed postgraduate activities of the California Medical Association is the most important thing that the California Medical Association can do today to offset criticism, and to raise the standard of the medical profession in this State. Most of the movements which have started under the term of "medical economics" have their inception in a criticism of services rendered. It is a sad but true commentary, therefore, on the medical profession that many physicians neglect their education upon beginning the practice of medicine.

The California Medical Association should realize that by means of postgraduate activities they are being given the greatest available weapon for combating the criticism of the medical profession.

With these facts in mind, the committee desires to make the following proposals:

1. The medical schools and the California Medical Association coöperate in presenting postgraduate conferences in order to avoid conflicting programs.
2. The office of the California Medical Association be used as the central bureau through which programs are arranged.
3. Conferences should be aimed to cover one subject thoroughly with clinical and case demonstration, and it is proposed that where more than one speaker or clinician instructor participate, each should demonstrate various phases of the subject, such as clinician, surgeon, pathologist, x-ray, etc., rather than four or five speakers on four or five subjects. Conferences should not be a series of didactic lectures such as are available at the various county medical meetings.
4. All conferences be held, if possible, in a local county hospital in order that a clinical demonstration may be given, and all facilities necessary therefor will be at hand. Case demonstration is important.

5. It is hoped that the local men may use these clinical case demonstrations as a consultative service for diagnostic problems by submitting their patients for demonstration.

6. All expenses incurred in the giving of postgraduate conferences to be borne by the California Medical Association and the county medical societies, these expenses to include remuneration to clinicians for travel and hotel expenditures.

7. Credits, in the form of certificates by the California Medical Association, to be issued to members attending these conferences for a specified number of hours.

8. Men to conduct postgraduate conferences to be obtained from the following sources:

(a) The teaching staffs of the University of California, Stanford University, the University of Southern California, the College of Medical Evangelists, and the Los Angeles Medical Department of the University of California.

(b) The rosters submitted by the California Tuberculosis Association, the California Heart Association, and the Cancer Commission of the California Medical Association.

(c) Men selected by the Committee on Postgraduate Activities from the membership of the California Medical Association.

The California Tuberculosis Association and the California Heart Association have offered their assistance in making postgraduate conferences a success, and either or both associations would pay one-half the expenses of a conference if the conference were given in lieu of one of their meetings. This statement was confirmed by Mr. W. F. Higby, Executive Secretary of the California Tuberculosis Association, and Dr. John C. Ruddock, President of the California Heart Association.

9. The Secretary of the California Medical Association to prepare a printed bulletin containing information as to courses and speakers for postgraduate conferences.

10. The Secretary of the California Medical Association to obtain information regarding available clinical conferences from: The University of California Medical School; Stanford University Medical School; the University of Southern California Medical School; College of Medical Evangelists; Los Angeles Medical Department of the University of California; California Tuberculosis Association; California Heart Association; Cancer Commission of the California Medical Association; Maternal and Child Welfare, Crippled Children, Department of Health; and such other departments as come under the Social Security Act.

Respectfully submitted,

Clarence G. Toland, *Chairman*.

COMMITTEE ON PUBLICATIONS

Executive Group

Percy T. Magan, Chairman, 1937	
Ruggles A. Cushman, 1938	Oscar Reiss, 1939
The Editor, ex officio	The Secretary, ex officio

To the President and the House of Delegates:

The chairman of your Committee on Publications takes pleasure in again calling to the attention of the members of the California Medical Association the excellence of its official journal, judged by the publications of other state medical societies as we find them on the shelves of our medical libraries.

We are glad to know that CALIFORNIA AND WESTERN MEDICINE appears on its monthly visits with splendid regularity. The articles it contains are the writings, for the most part, of the members of our California Medical Association, as given in the annual session of the State organization or in its component county societies. Therefore, it stands to reason that they represent in all probability the best we can produce. Your Publication Committee is of the opinion that the papers are of very good standard. If we have members who are able to write better papers, we trust they will awaken to the responsibility which they owe their professional brethren, and ask for places on the annual session programs.

We have no criticism to make of the general make-up of CALIFORNIA AND WESTERN MEDICINE. To us it appears

that the publication bears favorable comparison with those of other state medical societies.

In routine matters the editor is kind enough to bear the burden, and it is only occasionally that our committee is called upon to take part in the solution of extraordinary problems.

There has been proposed a plan for supplements. This was suggested by the editor and authorized by the Council, and with it we are in entire sympathy. Experience with such will soon decide whether they shall be permanent features for "Pre-Convention Bulletin," "Scientific Program," "Annual Directory of Members," and like special features.

In closing, we can only say that CALIFORNIA AND WESTERN MEDICINE is, for the most part, what the members of the Association choose to make it. This Committee on Publications makes an earnest appeal to our members to give the official journal the fullest possible support. It is the mouthpiece of organized and scientific medicine in California, and it should be an expression of the best we can produce. Moreover, it is our official journal, and the members of the California Medical Association are its owners. It should at all times be worthy of our great organization. *It can be* if each of us does his part!

Respectfully submitted,

Percy T. Magan, *Chairman.*

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Executive Group

Junius B. Harris, Chairman, 1938
E. T. Remmen, 1937 T. Henshaw Kelly, 1939
The President, ex officio The President-Elect, ex officio

To the President and the House of Delegates:

The Legislature being in session, your committee is refraining from making a formal report at this time. Your committee will be prepared to submit a complete report upon all legislative matters and events as they exist at the time when the House of Delegates will convene for its first 1937 session.

Respectfully submitted,

Junius B. Harris, *Chairman.*

COMMITTEE ON SCIENTIFIC WORK

Executive Group

Frederick C. Warnshuis, Chairman, ex officio
Lemuel P. Adams, 1937 F. M. Pottenger, 1939
J. Homer Woolsey, 1938 Edwin L. Bruck, ex officio
John M. Schmoele, ex officio

To the President and the House of Delegates:

The Scientific Committee respectfully submits this as its annual report.

The official program, governing the general meetings and section meetings, record the major activity of this committee. In joint cooperation with section officers, your committee studiously endeavored to arrange the scientific program along lines and subjects that would be productive in the enhancement of the medical knowledge of members. Your committee is of the opinion that it has been successful in attaining that purpose. Generous thanks are tendered to section officers for their valuable experience, the commendations expressed, and the interest shown in the past two years in the Clinical-Pathological Conference conducted during the second general session, induces your committee to request that the House of Delegates adopt the following resolution:

Resolved, That the second general session of each annual meeting shall be devoted to a Clinico-Pathological Conference conducted under the auspices of the Scientific Committee.

Scientific Exhibits.—Your committee has devoted much time to the development of and encouragement of a department of scientific exhibits as a part of the scientific program. We are convinced that it possesses increasing educational value and interests. The request is made that the House of Delegates endorse this program feature and authorize this committee to create a policy of awards in the form of certificates and nominal monetary prizes.

Scientific Committee Fund.—Your committee observes that during the past two years the Association's secretary has been able to return a financial profit from the commercial exhibits, after paying all of the expenses of an annual meeting. Your committee is of the opinion that this monetary profit should be used to create a scientific fund, this fund to be used for the development of scientific exhibits and scientific demonstrations at annual meetings.

Your committee recommends that the House of Delegates direct the Council to create such a fund from this source of revenue, disbursement of these funds for the mentioned object to be under control of the Council; and that a budget of expenditures be under control of the Council, and that a budget of expenditures be submitted to the Council for approval before any financial obligations are incurred.

Section Meetings.—Over a year ago your committee directed attention to the increasing attendance at annual meetings. The difficulties in providing adequate meeting places for twelve sections was pointed out. The suggestion was made that there be a rearrangement of sections and the amalgamation of certain sections. The suggestion was referred to the Council and again referred to this committee for further study and report.

Section officers were requested to discuss the subject with section members. At the meeting of section officers in January, plans were discussed. At that conference the following plan and proposal was agreed upon:

That the following full-time sections, holding four full sessions, be continued: General Medicine; Surgery; Obstetrics and Gynecology; Eye, Ear, Nose, and Throat; Pediatrics; Dermatology and Syphilology; and Urology.

That the following sections be transferred to the Department of Scientific Exhibits: Pathology and Bacteriology; Industrial Medicine and Surgery; and Radiology.

That Anesthesiology and Neuropsychiatry be amalgamated with Surgery and Medicine.

That officers of the seven scientific sections be directed to provide for program assignments for the three sections transferred to the Department of Scientific Exhibits.

That the five named sections be authorized to retain their identity, to elect officers, and to hold one session during the annual meeting for the presentation of certain specific subjects and questions that are of special interest to those engaged in these special fields.

Your committee recommends the adoption of this plan for experimental purposes for the 1938 annual meeting.

Respectfully submitted,

F. C. Warnshuis, *Chairman.*

COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is Charles A. Dukes, the secretary is Frederick C. Warnshuis. The director of the Department of Public Relations is Frederick C. Warnshuis. The chairman of the Committee on Public Relations is ex officio a member of the Council.

Fred B. Clarke, Chairman, Committee on Health and Public Instruction.

Daniel Crosby, Chairman, Committee on Hospitals, Dispensaries, and Clinics.

Morton R. Gibbons, Chairman, Committee on Industrial Practice.

E. Vincent Askey, Chairman, Committee on Membership and Organization.

John H. Graves, Chairman, Committee on Medical Economics.

Junius B. Harris, Chairman, Committee on Public Policy and Legislation.

Charles A. Dukes, Chairman, Cancer Commission.

Clarence G. Toland, Chairman, Committee on Postgraduate Activities.

Edward M. Pallette, President of California Medical Association.

Howard Morrow, President-Elect.
Frederick C. Warnshuis, Secretary-Treasurer.

To the President and the House of Delegates:

Your Committee on Public Relations respectfully transmits this annual report for the past Association year.

I. EXPLANATORY

During the year, in each issue of CALIFORNIA AND WESTERN MEDICINE, in the pages assigned to the Depart-

ment on Public Relations, your committee has diligently sought to keep the Association members informed in regard to this committee's plans and activities. In this report your committee will, therefore, confine itself to general summarizations.

II. PUBLIC HEALTH INSTITUTES AND HALL OF MEDICAL SCIENCE

Public Health Institutes were conducted in Santa Barbara, San Francisco, and Monterey.

Through the untiring efforts of Dr. Lyell C. Kinney, Dr. William H. Geistweit, Jr., and the Special Committee of the San Diego County Medical Society, and with the assistance of Dr. Clarence G. Toland and his State Committee, the Hall of Medical Science in the California Pacific International Exposition in San Diego was sponsored and operated by our Association. The Exposition closed in September, 1936. The exhibits were dismantled and returned.

(See Appendix to this report.)

Your committee is unable to evaluate the end-results of this outstanding activity. It may be concluded that the public gained much dependable health information for its future welfare. The profession gained in good will and the establishment of better public relations.

III. PUBLIC RELATIONS

Our relations with the public and lay organizations were strengthened, and were productive of desirable results by means of the following contacts, conferences, presentations and joint action with: Health Committee, Parent-Teachers' Association; State Highway Traffic Department; State Nurses' Association; State Chamber of Commerce; Federal and State Forestry Departments; Y. W. C. A.; State Hospital Association; Hospital Insurance Associations; and State Tuberculosis Association.

Through these and similar contacts, your committee feels assured that it is creating relationships that beget sound understandings conducive to the establishment of sound public opinions in regard to scientific medicine and private health welfare.

Your committee cites the encouraging fact that never before have so many lay inquiries for information and guidance been received at the Association's central office.

IV. RECOMMENDATIONS

1. Your committee recommends that the House of Delegates approve the state-wide establishment of the Public Health Hour in physicians' offices. Your committee requests that approval be given to this movement that will return clinic patients to the private offices of physicians, and that this committee be instructed to accomplish this as speedily as possible. The plan has been outlined on several occasions. Your committee feels that county societies should be directed to assume a prominent rôle in this very desirable health-conservation activity.

2. Because of the expense involved, the tremendous amount of local work to secure publicity and public interest, your committee recommends that Public Health Institutes be discontinued.

Your committee requests approval for its plan to acquire a library of educational films for public meetings to continue its program for public health education under county society sponsorship, and in coöperation with the Woman's Auxiliary.

Your committee recommends that it be empowered to aid in the formation of, and exercise guiding direction of Associated Medical Services under Senate Bill 605, or similar bill, if that legislation is enacted.

Respectfully submitted,

Charles A. Dukes, *Chairman.*

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SUPPLEMENTARY REPORT: ON THE MEDICAL EXHIBITS AT THE 1936 CALIFORNIA INTERNATIONAL EXPOSITION IN SAN DIEGO

The Council of the California Medical Association and the Council of the San Diego County Medical Association:

You have had presented to you the official report of the committee appointed by the San Diego County Medical

Society to have charge of the Hall of Medical Sciences at the California Pacific International Exposition. That report has covered the matter in detail.

I feel that it is only proper that the director make a supplemental report to you. Your committee served faithfully and well: each member carried out, to the fullest, the duties assigned to him. The record presented to you deserves your highest commendation. I desire to make special mention of Dr. M. C. Harding and Dr. L. C. Kinney, the latter being too modest to mention himself in the committee report. Doctor Harding's advice and moral backing, whenever it was necessary for Doctor Kinney to be away, was of invaluable service to your director. Without him we should have been in rather serious difficulty that would have jeopardized the exhibit. Doctor Kinney carried the heavy financial load until the Exposition Management reimbursed him through you. Without his help in that regard, the Hall of Medical Sciences would never have been presented as it was to the public. His advice and assistance, even in the actual installation of exhibits, made the exhibit what it was. I feel that it is only just that the medical profession know what these two men did. It is not flattery, but a simple statement of fact.

In some ways the work was onerous; yet all of us, now that it is over and past, take some pleasure and satisfaction in the efforts put forward to advance the medical profession in the eyes of the public.

Sincerely,

(Signed) W. H. Geistweit, Jr.,
Director, Medical Science Exhibit.

SUPPLEMENTARY REPORT: ON MEDICAL EXHIBITS AT THE 1936 CALIFORNIA PACIFIC INTERNATIONAL EXPOSITION AT SAN DIEGO

To the Council of the California Medical Association and to the Council of the San Diego County Medical Society:

On December 20, 1935, the Council of the San Diego County Medical Society appointed the undersigned committee to assemble and take charge of an exhibit on medical sciences at the 1936 California Pacific International Exposition. This committee was later appointed by Mr. Phillip Gildred, managing director, to be the official committee of the Exposition in charge of the Hall of Medical Sciences. The Committee appointed Dr. William H. Geistweit, Jr., to be Director of Medical Exhibits, and this appointment was, in turn, officially confirmed by Mr. Gildred.

Doctor Geistweit, coöperating with the sales department of the Exposition, put on a strenuous campaign to sell space to commercial exhibitors in order to finance the medical exhibit. This campaign was well planned and carefully and forcefully carried out, but was a complete failure. The collapse of this sales campaign was not known until the building was well under way and the exhibits partially assembled. The agreement with the Exposition was contingent on selling commercial space and neither the Exposition nor the Committee could foresee the failure of the commercial program.

Realizing that a project, sponsored by the American Medical Association, California Medical Association, and the San Diego County Society, could not be allowed to fail for any reason whatever, and that they had no legitimate right to call upon the Exposition to further finance an apparent failure, the Exposition Committee advanced the necessary funds to complete the Hall of Medical Sciences. Naturally, the Committee hoped to be reimbursed if the project was carried to a successful conclusion and proved to be an asset to the Exposition Company. This hope was realized and the Exposition Management has reimbursed the local committee through the sponsoring societies for all expenses incurred in assembling the exhibit, maintaining the building, dismantling, and return of the exhibits to their source.

This program, however, has involved the expenditure of money by the Committee and, therefore, a detailed report of that expenditure to the sponsoring societies is necessary, both to protect the societies and the Committee. Most of these accounts have been audited by the Expo-

sition Management, but they are presented in detail to you for final audit and approval. For convenience, this expenditure will be presented under six headings.

1. On December 22, 1936, the Exposition Management sent to Doctor Kinney a check to cover his promotion trip to Chicago, Detroit, Milwaukee, and Rochester for \$357.30. This check was endorsed to Doctor Geistweit, Director of Medical Exhibits, and used by him for promotion expense in his office. Doctor Geistweit's statement of this expenditure is presented herewith (No. 1). The balance in this account of \$42.31 is closed by a check for that amount, payable to Miss Verne Anderson, Secretary to the Director of Medical Exhibits.

2. During the assembly and installation of exhibits, the Committee spent \$2,907.33. The details of this expenditure and the receipted bills are presented herewith (No. 2). On April 27, after the Hall of Medical Sciences was completed and proved to be an accepted and valuable attraction, a statement of this expense was sent to Mr. Hal Hotchkiss, Vice-President of the Exposition Company. This expense account was audited by the Exposition, approved by the Board of Directors and reimbursement ordered. Payment was made in two checks of \$1,453.66 each on June 20 and August 28, payable to the California Medical Association and the San Diego County Medical Society. These checks were deposited by the California Medical Association and reimbursement checks issued to Doctor Kinney to cover the amount expended by the Committee.

3. During the interval between April 24 and the close of the Exposition, several late exhibits were received and installed, largely at the expense of the Committee. Also during this interval there was a considerable upkeep expense in the replacement of light and projection bulbs and repair of projection apparatus. These items amounted to \$251.42, the detail of which, including the receipted bills, is attached (No. 3). On September 3, a statement of this expense was sent to Mr. Frank Belcher, President of the Exposition, together with a late bill from the Stanford University for \$203.44 and a renewed request for the honorarium for Doctor Geistweit that had been promised by the Management on his appointment. These bills were also audited by the Exposition Company and paid October 8 by a check to the San Diego County Medical Society and the California Medical Association, amounting to \$854.86. The check was deposited by the California Medical Association and distributed as follows: Stanford University, \$203.44; Doctor Geistweit, \$400; and reimbursement to Doctor Kinney, \$251.42.

4. On the closing of the Exposition, the Committee assumed the expense of dismantling exhibits not otherwise provided for and the return of these exhibits to their source. Two other items of expense arose at this time, the bill for the incoming transportation of the exhibit of the Chicago Roentgen Society and the replacement of two losses by theft—a hat from the Western Costume Company, and a microscope belonging to Dr. John Flude. The Committee paid these bills, settling all claims and accounts, amounting to \$687.36. A statement of this expense (No. 4) was forwarded to the Board of Directors of the Exposition and paid by them without audit on November 20. This check was also paid to the San Diego County Medical Society and the California Medical Association and deposited by the California Medical Association.

5. A motion-picture film on laboratory procedure was prepared by Dr. A. G. Foord of Pasadena for the Hall of Medical Sciences, and this was authorized by the chairman of the Exposition Committee of the California Medical Association and by the chairman of the local committee. This film was to have been used as a part of the educational program in the auditorium, which program proved to be unsuccessful and had to be abandoned. The film was not ready until after the closing of the auditorium and was not used. However, Doctor Foord had offered to present this film to the California Medical Association for use in their Public Health Institute and the film was prepared for this ultimate use. This expense, while not chargeable to the Exposition Company, is a liability of the Committee. This one item of expense incurred in the Hall of Medical Sciences is presented to the Council of the California Medical Association for

their consideration. If the Council can use Doctor Foord's film as ultimately planned in their program of public health education, and if the Council sees fit to reimburse him for the \$250 spent in the preparation of the film, this action will close all liability of the Committee of the California Medical Association and the local Exposition Committee.

6. During the Century of Progress, the Council of the California Medical Association passed a resolution, requesting the American Medical Association to prepare a folio of photographs of the medical exhibits. Stimulated by this action of the Council in 1933, the local committee had photographs made of all exhibits and thus prepared a permanent record of the Hall of Medical Sciences. Copies of these books were sent to the American Medical Association, the California Medical Association, and the San Diego County Medical Society. Books were also given to the Director of Medical Exhibits, the Chairman of the California Medical Association Committee, and to the assistant director, Dr. M. C. Harding. The total expense of preparing these six books was \$243.67 (No. 5). The Committee respectfully suggests that the Council of the California Medical Association pay one-third of this expense, namely, for the records filed in the California Medical Association office, and the American Medical Association headquarters. The remaining two-thirds of this account is a charge against the local committee and will be absorbed by them.

Thus, the Committee for the San Diego County Medical Society and the Exposition have expended during the Exposition, \$5,300.53. In spite of the complete failure of the Committee to obtain commercial exhibits, the Exposition Management has paid all bills presented to them and have reimbursed the California Medical Association and the San Diego County Medical Society by checks amounting to \$4,806.86.

When the proposal of a medical exhibit was first made to the Committee of Public Relations of the California Medical Association, Doctor Kinney, for the Exposition Company, agreed to hold the California Medical Association free from all liability for the Hall of Medical Sciences. This obligation has been fulfilled; all bills have been paid and all liabilities covered, and reimbursement has been made by the Exposition Company. Only two items of expense are herewith presented to the Council, namely, Doctor Foord's educational film and the permanent records for the California Medical Association and the American Medical Association. While these seem to be a legitimate expenditure of California Medical Association funds, and apart from the expense of the Hall of Medical Sciences, the Committee assumed these two items without previously granted authority from the Council and will gladly pay them if the Council of the California Medical Association so directs.

The Committee, in compliance with its agreement with the California Medical Association and the American Medical Association, has submitted all its actions, every item of policy, all proposed exhibits, and all questions of conduct to Dr. C. G. Toland, Chairman of the Committee of the California Medical Association, and has received from him his approval. No action has been taken without such approval. Further, the Committee calls attention to the fact that no local exhibits were invited or accepted in the Hall of Medical Sciences, except that of the San Diego County Board of Health. Many local physicians assisted in loaning necessary items for the completion of general exhibits, but no recognition was given or permitted for this courtesy and assistance. Grateful recognition should be made at this time to Doctors C. W. Brown, Ray Lounsbury, Clyde Osborne, H. A. Thompson, M. C. Harding, Howard Ball, and C. E. Rees. The Committee cannot close this final report without acknowledgment of the splendid support it has received throughout the year.

1. The officials of the Exposition Company have kept their agreements to the letter. They have deferred in all matters of policy to Doctor Toland, Chairman of the California Medical Association Committee, and have accepted without question the decisions of Doctor Geistweit, the director, in all matters of detail in the installing and conducting of the exhibits of the Hall of Medical Sciences.

Finally, they have paid, without discussion, all bills presented to them by the Committee.

2. The Committee appreciates the constant and sympathetic support of Dr. C. G. Toland and the Committee of the California Medical Association. They have never called upon the California Medical Association Committee without receiving their wholehearted support. Their liaison with the California Medical Association, their procuring numerous and valuable exhibits and their advice and coöperation, were indispensable to the success of the project.

3. The Committee cannot too warmly commend the coöperation of the many organizations that contributed exhibits to the Hall of Medical Sciences. While lack of time made it impossible to meet the hope and expectations of the Committee in placing exhibits, the uniformly courteous, generous, and harmonious participation should be as gratefully appreciated by the state and county societies, as it was by the Committee in charge.

4. The Committee extends its sincere thanks to the Director of Medical Exhibits, Dr. William H. Geistweit, Jr., for his untiring effort and his splendid executive ability in representing the medical profession of California in this project. We feel that the Committee and the profession are deeply indebted to him for the successful completion and conduct of the Hall of Medical Sciences.

5. One of the finest achievements of the Exposition was that of the Woman's Auxiliary to the San Diego County Medical Society and of the Chairman of the Committee, Mrs. C. E. Howard. Every day throughout the nine months, members of the Auxiliary were on duty in the hostess booth of the Hall of Medical Sciences. This constant and complete coverage by the loyal women of the Auxiliary was a welcome surprise to all concerned, and was a splendid example of the power and efficiency of that organization.

6. The thanks of the Committee are extended to the Council of the San Diego County Medical Society for their approval and support throughout the year. The Committee finally extends its thanks and appreciation to the Council and officers of the California Medical Association for their confidence, support, and coöperation. Without the initial approval of Dr. C. A. Dukes and Dr. F. C. Warnshuis and their prompt action, the exhibit would never have been attempted. Without the effort of Doctor Warnshuis, the essential coöperation and the exhibit of the American Medical Association could not have been obtained. Without the action of Doctor Dukes, the fine exhibit from the Mayo Foundation was impossible. Also, the Committee fully realizes the great value and the popular attraction of the exhibit of the Public Health Institute and appreciates the action of the Council in loaning this exhibit for the duration of the Exposition.

The Committee of the San Diego County Medical Society submits this final report with the request that it be audited by the Council of the Society and the Council of the California Medical Association. If found in order and approved by your honorable bodies, and if the consent of the Council of the California Medical Association is granted, the Committee requests that it be relieved from further responsibility and discharged.

Respectfully submitted,

(Signed) James F. Churchill
W. W. Crawford
T. O. Burger
M. C. Harding
Alex Lesem
B. F. Eager
W. C. Crabtree
Lyell C. Kinney, *Chairman*.

SUMMARY

Expense—Hall of Medical Sciences:		
Promotion expense	\$	357.30
Assembly and installation of exhibits..	2,907.33	
Late exhibits and upkeep	251.42	
Stanford University	203.44	
Dr. Geistweit	400.00	
Dismantling, losses and transportation	687.36	\$4,806.85
Dr. Foord's film	250.00	
Permanent record, six copies	243.67	
Total		\$5,300.52

RECEIVED FROM THE EXPOSITION COMPANY

December 22, promotion check	\$	357.30
June 10, check to California Medical Association and San Diego County Medical Society	1,453.66	
August 28, check to California Medical Association and San Diego County Medical Society	1,453.66	
October 8, check to California Medical Association and San Diego County Medical Society	854.86	
November 20, check to California Medical Association and San Diego County Medical Society	687.36	
		\$4,806.85

V

REPORTS OF SPECIAL AND COUNCIL COMMITTEES

COMMITTEE ON ARRANGEMENTS

Executive Group

Paul M. Hunter	J. A. Merrill, Chairman	Mast Wolfsohn
E. F. Kehr		H. Spencer Hoyt

To the President and the House of Delegates:

Your committee has had several conferences with the State Secretary. Your committee's efforts are represented in the official program of this annual session.

On behalf of all the members of the Monterey County Medical Society, we extend a cordial and hearty greeting and fraternal welcome to every member attending this annual Session. During your session it will be our sustained endeavor to accord to every member the fullest hospitality.

Respectfully submitted,
J. A. Merrill, *Chairman*.

AUDITING COMMITTEE

(A Council Committee)

Executive Group

Karl L. Schaupp, Chairman	T. Henshaw Kelly
O. D. Hamlin	

To the President and the House of Delegates:

In compliance with the provisions of the by-laws, we will submit a draft of the 1937-1938 budget at the opening session of the House of Delegates.

Respectfully submitted,
Karl L. Schaupp, *Chairman*.

CANCER COMMISSION

Executive Group

Charles A. Dukes, Chairman	
Lyell C. Kinney, Vice-Chairman	
Alson R. Kilgore, Secretary	
Orville Meland, Secretary for Southern Section	
A. Herman Zeiler	Harold Brunn
Gertrude Moore	Henry J. Ullmann
Clarence G. Toland	

To the President and the House of Delegates:

Activities of the Cancer Commission have been devoted during the current year to public education.

The American Society for the Control of Cancer was invited to extend its national campaign to California. The Commission is working with the Society's representatives in the development of the 1937 Woman's Field Army drive.

Respectfully submitted,
Alson R. Kilgore, *Secretary*.

SUPPLEMENTAL REPORT OF THE CANCER COMMISSION

To the President and the House of Delegates:

At the Coronado session, a resolution was introduced instructing the Council of the California Medical Association to undertake the study of the relationship of trauma to malignancy. This matter was referred by the

Council to the Cancer Commission under date of September 29, 1936.

Your committee respectfully desires to report that this is a matter that will require much longer study than the time available before the 1937 meeting. Your committee, therefore, is not able to report on this question and resolution at this time and substitutes this report of progress.

Respectfully submitted,

Alson R. Kilgore, *Secretary*.

SPECIAL COMMITTEE ON A QUALIFYING CERTIFICATE (BASIC SCIENCE) LAW

Executive Group

George H. Kress, General Chairman

Morton R. Gibbons, Chairman (for Bay Region)

Edward M. Palette, Chairman (for Southern California)

Junius B. Harris, Chairman (for Remainder of State)

To the President and the House of Delegates:

The need of a qualifying certificate or basic science law is attested by the efforts of the naturopathic group to secure legal recognition from the Legislature now in session through the establishment of another cultist board of examiners in the State. If a previous experience with a cultist group is a precedent, such a board could and might probably license some hundred or perhaps one or more thousand healing-art practitioners who, professing allegiance to its tenets at the present time, would claim the right to have licenses without examination! The educational influence upon the mind of the layman through such lowering of standards is demoralizing and leaves its depreciating effects even upon scientific medicine. At the time of this writing it is not possible to state with any accuracy what will be the course of this supposed naturopathic board licensing law.

In previous reports your special committee has listed the reasons why a qualifying certificate (basic science) law must be an initiative law.

The cost of securing the 186,387 needed signatures (the number based on the 1936 Presidential-State elections) will be very considerable, but that cost, high though it may seem, is only a faint fraction of the indirect cost which every physician in the State would have if an additional 1 to 5,000 cultists secure legal recognition to practice in California on what, in the minds of many voters, would be equal rights with nonsectarian physicians and surgeons. The House of Delegates at Del Monte must keep this prospective expense in mind, because if initiative petitions for a qualifying certificate (basic science) law are to be circulated for the State election in October, 1938, the proposed law in its final draft and the petitions must be started on their course in the first months of 1938, in all probability before the 1938 annual session. The matter is of extreme importance, and decision should be made at Del Monte. For those who wish to acquaint themselves with the subject, a list of references is appended in a footnote.*

Respectfully submitted,

George H. Kress, *General Chairman*.

* A list of reports on qualifying certificate laws, printed in CALIFORNIA AND WESTERN MEDICINE, includes:

Vol. 32, No. 4, April, 1930, page 288. One hundred and eighty-sixth meeting of the Council of the California Medical Association. Item 30, Medical Practice Act and Basic Science Act.

Vol. 32, No. 6, June, 1930, page 430. Report of Special Committee on Revision of Medical Practice Act and of a possible Basic Science Act.

Vol. 34, No. 6, June, 1931, page 448. Report of Special Committee on California Medical Practice Act and on a Proposed Qualifying Certificate (so-called Basic Science) Law.

Vol. 35, No. 3, September, 1931, page 228. Editorial.

Vol. 35, No. 3, September, 1931, page 239. Miscellany.

Vol. 36, No. 2, February, 1932, page 128. Report of Special Committee on Medical Practice Act and on Qualifying Certificate Law.

Vol. 36, No. 6, June, 1932, page 439. Report of Special Committee on California Medical Practice Act and on a Qualifying Certificate (so-called Basic Science) Law.

Vol. 41, No. 5, November, 1934, page 339.

REPORT OF THE COMMITTEE OF FIVE

Executive Group

William R. Molony, Sr., Chairman

Harry Wilson

Alson R. Kilgore

Robert Peers

Rodney Yoell

To the President and the House of Delegates:

Your Committee of Five, which was charged by the House of Delegates with the responsibility of supervising a medical economic survey for the State of California, reports that this survey was made possible through the joint action and coöperation of the federal authorities, acting through the Works Progress Administration and the California State Board of Health on the one hand, and the California Medical Association on the other. The expenses of the offices, stationery, and supervising director and assistant personnel were borne by the California Medical Association, something like \$35,000 having been disbursed through requisition upon the State Association. The expense of field workers was covered by moneys received from the federal authorities, as above noted. The Committee of Five employed Prof. Paul A. Dodd of the University of California at Los Angeles to act as director of the survey, he working under the Committee of Five.

A large mass of material has been collected, but we understand this is construed to be the property of the federal authorities, who, until other arrangements are made, will place the same under the custodianship of the California State Board of Health.

Professor Dodd, in February of this year, submitted to the Federal Authorities and the State Board of Health his complete report which is now being studied by representatives of the various interests concerned.

Your Committee of Five will make an additional report to the Council of the California Medical Association, which body, in turn, may wish to make certain recommendations to the House of Delegates.

In closing, it is only proper to state that many difficulties have been encountered in this work, but it now looks as if the survey can be brought to a proper conclusion through the kind coöperation of the Federal Authorities and the State Board of Health.

Respectfully submitted,

The Committee of Five

By Harry H. Wilson

Alson Kilgore

Robert Peers

Rodney Yoell

William R. Molony, Sr., *Chairman*.

COMMITTEE ON CODIFICATION OF MEDICAL PRACTICE ACT

COMMITTEE ON VENEREAL DISEASE PROBLEM

COMMITTEE ON HEALTH AND/OR HOSPITALI- ZATION PLANS

Subject matter of reports of the three committees noted above will be considered in the Council's report to the House of Delegates.

Vol. 42, No. 1, January, 1935, pages 39 and 53.

Vol. 43, No. 4, October, 1935, page 304.

Vol. 43, No. 5, November, 1935, page 321. Editorial.

Vol. 43, No. 6, December, 1935, page 395. Editorial.

Vol. 44, No. 1, January, 1936, page 2. Editorial.

Vol. 44, No. 4, April, 1936, page 252. Editorial.

Vol. 44, No. 4, April, 1936, page 349. Special Article.

Vol. 45, No. 3, September, 1936, page 218. Editorial.

Vol. 46, No. 1, January, 1937, page 4. Editorial.

APPENDIX

HISTORICAL NOTES — PAST PRESIDENTS

CALIFORNIA MEDICAL ASSOCIATION:
HISTORICAL NOTES.

The California Medical Association came into existence in the year 1856 with B. F. Keene, M. D., of El Dorado as its first president, he being succeeded in office by H. Gibbons, M. D., of San Francisco.

The organization in its earlier days was known as the Medical Society of the State of California, the present name being adopted in the year 1924 in order to conform to the nomenclature in use by the constituent state medical units of the American Medical Association.

During the sixties the state medical society was somewhat quiescent; but in 1870 it was reorganized, when the first president under the reorganization was T. M. Logan, M. D., of Sacramento.

In 1873 appeared the first copy of the annual "Transactions of the Medical Society of California," a volume published each year, until Volume 31 was issued in April of 1901. In that year it was recommended that, since the annual transactions were "an extravagant and unnecessary way of perpetuating the proceedings of the society, the more rational one of publishing a monthly journal" be adopted. Thus, "The California State Journal of Medicine" came into existence, its name being changed to "California and Western Medicine" in the year 1924. The late Philip Mills Jones, M. D., may be looked upon as the founder of the official journal.

The first volume of Annual Transactions, printed in 1873, is interesting to glance through, with a roster of some 195 "permanent members" of the state society; for under that name the regular members were so designated at that time.

In the earlier days, owing to the difficulties of travel, the state medical society was practically an almost exclusively northern organization, its counterpart in Southern California being the Southern California Medical Society, which was founded in the year 1888.

It gives one, therefore, a distinct shock to note that, of the 195 members in the year 1873, all but seven were from north of the Tehachapi, the seven southern members being credited as follows: Santa Barbara, four; San Diego, two; and Los Angeles, one! The Los Angeles representative at that time was J. P. Widney, M. D., who was the founder of the Los Angeles County Medical Association. Doctor Widney was also the founder and the first dean of the College of Medicine of the University of Southern California, and later, for a time, the president of that university.

With the reorganization of the state society, which followed on that of the American Medical Association in 1901, the picture changed.

For in that year began the national association system made up of state society units, and these in turn composed of component county societies, only one such county unit being permitted for each county.

From that time, too, to the present day the state organization has increased in numbers of members, scope and influence, until now it is among the largest of the state units which make up the American Medical Association.

With a record of service well rendered over a period of many decades, the California Medical Association looks forward in firm faith to promising days still to come, which shall be full of even greater achievement.

PRESIDENTS OF THE CALIFORNIA MEDICAL
ASSOCIATION, 1856-1937

NAME	YEAR
*B. F. KEENE.....	1856
*H. GIBBONS, JR.....	1857
*A. B. STOUT.....	1858
*R. B. ELLIS.....	1859
No sessions (1859-1870)	
*T. M. LOGAN.....	1870
*H. GIBBONS, SR.....	1871
*G. A. SHURTLEFF.....	1872
*T. H. PINKERTON.....	1873
*J. M. BROWNE.....	1874
*A. B. NIXON.....	1875
*WILLIAM FITCH CHENEY.....	1876
*WASHINGTON AYER.....	1877
*H. S. ORME.....	1878
*A. W. SAXE.....	1879
*F. W. TODD.....	1880
*G. G. TYRRELL.....	1881
*L. C. LANE.....	1882
*L. E. OATMAN.....	1883
*R. B. COLE.....	1884
*W. P. GIBBONS.....	1885
*W. S. THORNE.....	1886
*R. H. PLUMMER.....	1887
*JAMES SIMPSON.....	1888
*WALTER LINDLEY.....	1889
*W. R. CLUNESS.....	1890
*O. O. BURGESS.....	1891
*W. E. TAYLOR.....	1892
*C. G. KENYON.....	1893
*G. L. SIMMONS.....	1894
*W. LEMOYNE WILLS.....	1895
*HENRY GIBBONS, JR.....	1896
*CEPHAS L. BARD.....	1897
*WILLIAM WATT KERR.....	1898
*GEORGE CHISHMORE.....	1899
*THOMAS ROSS.....	1900
*WILLIAM J. G. DAWSON.....	1901
*F. B. CARPENTER.....	1902
*H. BERT ELLIS.....	1903
*FRANK L. ADAMS.....	1904
*R. F. ROONEY (first term)†.....	1905
*R. F. ROONEY (second term).....	1906
GEORGE H. EVANS.....	1907
350 Post Street, San Francisco	
*WESLEY W. BECKETT.....	1908
*JAMES H. PARKINSON.....	1909
JOHN C. KING.....	1910
990 Atchison Street, Pasadena	
*THOMAS W. HUNTINGTON.....	1911
O. D. HAMLIN.....	1912
Federal Realty Building, Oakland	
*F. C. E. MATTISON.....	1913
*H. M. SHERMAN (first term).....	1914

* Deceased.

† Year of San Francisco Fire. Annual Session did not convene after first day.

NAME	YEAR
*H. M. SHERMAN (second term)†.....	1915
GEORGE H. KRESS.....	1916
945 Roosevelt Building, Los Angeles	
*J. H. BARBATT.....	1917
*C. VAN ZWALENBURG.....	1918
*H. A. L. RYFKOGEL.....	1919
*JOHN C. YATES.....	1920
JOHN H. GRAVES.....	1921
977 Valencia Street, San Francisco	
*H. G. BRAINERD.....	1922
*THOMAS C. EDWARDS.....	1923
*GRANVILLE MACGOWAN.....	1924
EDWARD N. EWER.....	1925
251 Moss Avenue, Oakland	
*WILLIAM T. MACARTHUR.....	1926

* Deceased.

† Year of A. M. A. meeting in San Francisco. No annual session convention.

NAME	YEAR
*PERCY T. PHILLIPS.....	1927
WILLIAM H. KIGER.....	1928
1930 Wilshire Boulevard, Los Angeles	
MORTON R. GIBBONS.....	1929
350 Post Street, San Francisco	
LYELL C. KINNEY.....	1930
1831 Fourth Street, San Diego	
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1127 Eleventh Street, Sacramento	
JOSEPH M. KING.....	1932
727 West Seventh Street, Los Angeles	
GEORGE G. REINLE.....	1933
532 Fifteenth Street, Oakland	
CLARENCE G. TOLAND.....	1934
1930 Wilshire Boulevard, Los Angeles	
ROBERT A. PEERS.....	1935
Colfax, California	
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1930 Wilshire Boulevard, Los Angeles	
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803 Fitzhugh Building, 384 Post Street, San Francisco	

M E M O R A N D A

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		John C. Ruddock.....Los Angeles	1937
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(Roster lists of officers of scientific sections, component county societies, Woman's Auxiliary, A. M. A. delegates, special committees, etc., are continued on advertising pages 4 and 6.)

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(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, H. Gordon MacLean, 230 Grand Avenue, Oakland.
Secretary, Gertrude Moore, 2404 Broadway, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte County Medical Society
President, John H. White, 315 Wall Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Clara H. Spalding, 331 Eighth Street, Richmond.
Secretary, Thomas J. Dozier, 202 G Street, Antioch.
Meeting, *Second Tuesday, 8 p. m.*

Fresno County Medical Society
President, J. M. Frawley, T. W. Patterson Building, Fresno.
Secretary, O. B. Doyle, Bank of America Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Allan R. Watson, 350 E Street, Eureka.
Secretary, Lawrence A. Wing, Fifth and F Streets, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Floyd A. Burger, Box 193, El Centro.
Secretary, Merritt C. Canfield, 204 Professional Building, El Centro.
Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

Kern County Medical Society
President, H. R. McAllister, Professional Building, Taft.
Secretary, C. S. Compton, 428 C Street, Bakersfield.
Meeting, *Third Thursday, 8:30 p. m.*

Kings County Medical Society
President, P. K. Edmunds, Corcoran.
Secretary, William A. Johnstone, Hanford.
Meeting, *Second Monday, 8 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, C. I. Burnett, Susanville.
Secretary, Fred J. Davis, Jr., Westwood.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, John P. Nuttall, 203 Professional Building, Santa Monica.
Secretary, E. Vincent Askey, 1925 Wilshire Boulevard, Los Angeles.
Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Anne L. Brady, Albert Building, San Rafael.
Secretary, Carl W. Clark, 510 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society
President, Thomas P. Hill, Lakeport.
Secretary, Charles A. Craig, Lakeport.
Meeting, *On Call.*

Merced County Medical Society
President, Max Brannon, Merced.
Secretary, Fred O. Lien, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Garth Parker, 8 East Alisal Street, Salinas.
Secretary, Arthur L. Wessels, Salinas National Bank Building, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, Fred Heegler, Migliavacca Building, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Society
President, Waldo S. Wehrly, 620 N. Main St., Santa Ana.
Secretary, Glenn Curtis, 323 So. Pomona Street, Brea.
Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital, Orange.*

Placer County Medical Society
President, C. E. Lewis, 59 Lincoln Ave., Auburn.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, H. L. Ratliff, 3616 Main Street, Riverside.
Secretary, Thomas A. Card, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Raymond M. Wallerius, 312 Physicians Building, Sacramento.
Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, L. C. Hull, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, D. C. Mock, 215 Cajon Street, Redlands.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego
President, S. J. McClendon, 2001 Fourth Street, San Diego.
Secretary, W. H. Newman, Medico-Dental Building, San Diego.
Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, T. Henshaw Kelly, 490 Post Street, San Francisco.
Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.
Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, John S. Blinn, 1101 Medico-Dental Building, Stockton.
Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Charles R. Kennedy, Bank of America Building, Paso Robles.
Secretary, E. D. Anderson, 1120 Morro Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Mulholland's Grill, San Luis Obispo.*

(Roster lists continued on advertising page 6)

San Mateo County Medical Society
President, Frank S. Gregory, 736 Main Street, Redwood City.
Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Irving Wills, 1421 State Building, Santa Barbara.
Secretary, William H. Eaton, 822 De la Guerra Terrace, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, R. Stanley Kneeshaw, 404 Medico-Dental Building, San Jose.
Secretary, Leslie B. Magoon, Medico-Dental Building, San Jose.
Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society
President, A. N. Nittler, 36½ Pacific Avenue, Santa Cruz.
Secretary, Samuel B. Randall, Farmers and Merchants Bank Building, Santa Cruz.
Meeting, *Second Tuesday, 7:30 p. m., Hotel Rio del Mar, Aptos.*

Shasta County Medical Society
President, Oscar J. Hansen, 318 Yuba Street, Redding.
Secretary, Leslie J. Seeley, 1432 York Street, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, E. F. Carlson, Fort Jones.
Secretary, J. B. McGuire, Mt. Shasta City.
Meeting, *Second Sunday.*

Solano County Medical Society
President, H. Brownlie Perkins, 445 Georgia Street, Vallejo.
Secretary, John W. Green, Box 539, Vallejo.
Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, C. B. Andrews, Sonoma.
Secretary, C. M. Carlson, 1055 Fourth Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Marion C. Collins, Turlock.
Secretary, Edwin F. Hagedorn, Box 834, Modesto.
Meeting, *Second Friday.*

Tehama County Medical Society
President, Donald E. Thompson, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, J. C. McClure, Lindsay.
Secretary, Karl F. Weiss, Security First National Bank Building, Visalia.
Meeting, *Sunday Evening once a month.*

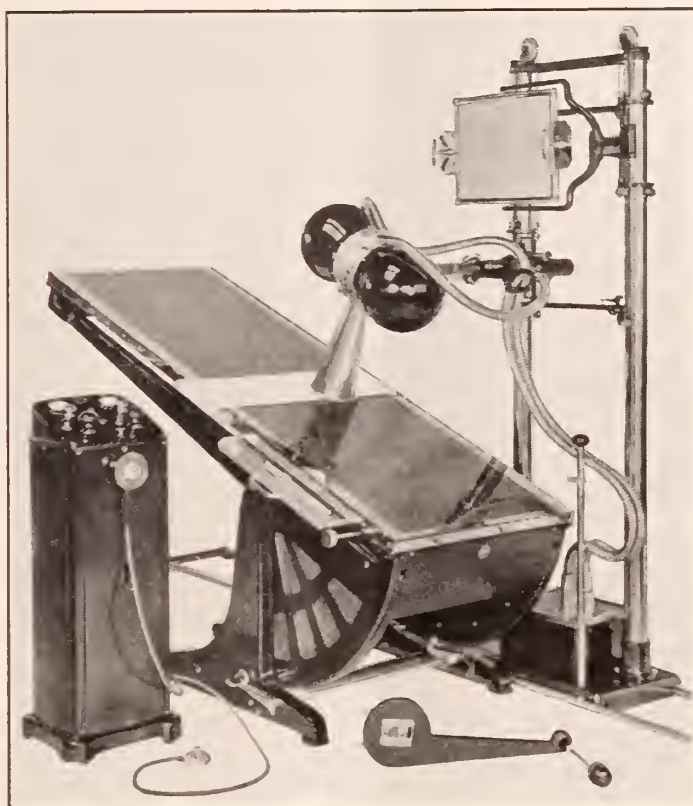
Ventura County Medical Society
President, F. R. Hendricks, 885 East Main Street, Ventura.
Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society
President, Stanley E. Coffey, 239 Fourth Street, Orland.
Secretary, Ray E. Nichols, Woodland.
Meeting, *First Tuesday.*

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Board of Medical Examiners of the State of California San Francisco, Rm. 512, 450 McAllister St. Los Angeles, 812 Associated Realty Building, 510 West Sixth Street. Sacramento, 420 State Office Building. President, William R. Molony, Sr., Los Angeles. Secretary, C. B. Pinkham, Room 512, 450 McAllister Street, San Francisco.		
The Public Health League of California Executive Secretary, Ben H. Read. San Francisco Office, 450 Sutter Street. Los Angeles Office, Room 563, 1151 South Broadway.		
Better Health Foundation President, Reginald Knight Smith, 490 Post Street, San Francisco. Chairman, Executive Committee, Walter B. Coffey, 65 Market Street, San Francisco. Treasurer, John Gallwey, 1195 Bush Street, San Francisco. Secretary, Celestine J. Sullivan, 490 Post Street, San Francisco.		
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(1936).

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Dec. 10, 1936

E. Podolsky: N. Y. M. J. (Nov., 1930).

"Bee-Venom Therapy," B. F. Beck, M. D.: Published by
D. Appleton-Century Co., N. Y. (1935).

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Allen, Wilbur, and McLean (Proc. Cent. Soc. Clin. Res., Nov. 6, 1936) also report 80 per cent improvement of symptoms in ninety-five cases suffering from melancholia, chronic fatigue or exhaustion.

Dry Serum Tests at University of California Hospital Are Encouraging.—Experiments made by the University of California Medical School with dry serums, including human serum, have proved so encouraging that every effort will be made to increase their scope and effectiveness, it is announced by the Pediatrics Department of the School. It has been found that the dry serums are less likely to undergo change or deterioration than the wet serums, and this long-sustained potency is having a very definite effect in the treatment of such diseases as scarlet fever and measles in the University Hospital.

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by the Lyophile. However, due to a number of governing conditions, the pediatrics department has been unable to use the Lyophile output on human patients, finding it necessary to obtain the desiccated substances elsewhere for this purpose. It is hoped that some means will be found to obtain a larger apparatus and to so adjust present restrictions, that the department will be enabled to desiccate all of the serums used in its clinic and hospital treatments.

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Preliminary Pain in Coronary Thrombosis.—Feil believes that in about 50 per cent of patients the attack of coronary thrombosis is preceded by angina, unrelated to effort or emotion. He has seen fifteen cases with sub-sternal pain preceding the onset of the severe symptoms by hours or days. Substernal or epigastric (rarely precordial) pain is complained of—mild, not related to effort or emotional strain, not severe enough to confine the patient to bed and often not severe enough to lead the patient to consult a physician. This pain is more or less constant, is of a burning and oppressive character and is not relieved by rest or by nitrites. The pain lasts from a few hours to four weeks. If the physician is consulted, he finds no change in the objective symptoms—the blood pressure is unaltered and there is no fever or leukocytosis. The heart sounds are unchanged. After a variable period of preliminary pain, the clinical picture of acute coronary thrombosis suddenly makes its appearance and with it the typical electrocardiographic changes. This preliminary pain occurred in approximately 50 per cent of the cases of coronary thrombosis observed in the last two years. The nature of the preliminary pains was suspected in three of the fifteen cases.—*American Journal of Medical Sciences.*

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BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

Clinical Laboratory Diagnosis. By Samuel A. Levinson, M. S., M. D., Director of Laboratories, Research and Educational Hospitals, Chicago, Illinois; Associate Professor of Pathology and Bacteriology and Assistant Professor of Medicine, University of Illinois College of Medicine, and Robert P. MacFate, Ch. E., M. S., Assistant Director of Laboratories, Research and Educational Hospitals, Chicago, Illinois; Associate in Pathology and Bacteriology and Instructor of Physiological Chemistry, University of Illinois College of Medicine. Cloth. Pp. 877, illustrated with 144 engravings and 13 plates. Philadelphia: Lea & Febiger, 1937.

Handbook of Orthopedic Surgery. By Alfred Rives Shands, Jr., B. A., M. D., Associate Professor of Surgery in charge of Orthopedic Surgery, Duke University School of Medicine, and Chief of the Orthopedic Service, Duke Hospital, Durham, North Carolina; Member of the American Orthopedic Association, the American Academy of Orthopedic Surgeons, and the International Society of Orthopedic Surgery. In Collaboration with Richard Beverly Raney, B. A., M. D., Instructor in Orthopedic Surgery, Duke University School of Medicine. Cloth. Pp. 593, with 169 illustrations. Price, \$5. St. Louis: The C. V. Mosby Company, 1937.

Ophthalmoscopy, Retinoscopy and Refraction. With New Chapter on Orthoptics. By W. A. Fisher, M. D., F. A. C. S., Chicago, Professor of Ophthalmology, Chicago Eye, Ear, Nose and Throat College; Formerly Professor of Clinical Ophthalmology, University of Illinois, etc. Fourth revised edition. Pp. 210, with 240 illustrations, including 24 colored plates. Price, \$2 postpaid. Chicago: H. G. Adair Printing Company, 1937.

Senile Cataract. Methods of Operating. By W. A. Fisher, M. D., F. A. C. S., Professor of Ophthalmology, Chicago Eye, Ear, Nose and Throat College, Formerly Professor of Clinical Ophthalmology, University of Illinois; etc. With Chapters by Prof. E. Fuchs, Vienna, Austria; Prof. I. Barraquer, Barcelona, Spain; Dr. H. T. Holland, Shikarpur, Sind, India; Dr. John Westley Wright, Columbus, Ohio; Dr. A. Van Lint, Brussels, Belgium. Third revised edition. Cloth. Pp. 150, with 181 illustrations. Price, \$2 postpaid. Chicago: The H. G. Adair Printing Company, 1937.

Sexual Power. By Chester Tilton Stone, M. D., Clinical Assistant Surgeon in the Urological Department, Bellevue Hospital; Consultant Urologist to the Rome State School, New York. Cloth. Pp. 172, illustrated. New York: D. Appleton-Century Company, Inc., 1937.

(Continued on Next Page)

NEW MEDICAL BOOKS

Bradhy & Kahn: Trauma and Disease.....	\$7.50
Cecil: Diagnosis and Treatment of Arthritis....	4.75
Eddy & Dalldorf: The Avitaminoses.....	4.50
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"Sinusitis—Shall Treatment be Surgical or Non-Surgical," Eye, Ear, Nose and Throat
Monthly, Sept., 1936, by Irving Voorhees, M. D.

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BOOKS RECEIVED

(Continued from Preceding Page)

Surgical Pathology of the Thyroid Gland. By Arthur E. Hertzler, M. D., Surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas, Professor of Surgery, University of Kansas. Cloth. Pp. 298, with 238 illustrations. Philadelphia: J. B. Lippincott Company, 1936.

The Thyroid and Its Diseases. By J. H. Means, M. D., Jackson Professor of Clinical Medicine, Harvard University and Chief of the Medical Service, Massachusetts General Hospital. Being an Account Based in Large Measure on the Experience Gained in the Thyroid Clinic of the Massachusetts General Hospital. Cloth. Pp. 602. Philadelphia: J. B. Lippincott Company, 1937.

Medical Greek and Latin At a Glance. By Walter R. Agard, B. Litt (Oxon.) Professor of Greek, University of Wisconsin. With an Introduction by C. H. Bunting, M. D., Professor of Pathology, University of Wisconsin. Second

edition revised. Cloth. Pp. 87. Price, \$1.50. New York: Paul B. Hoeber, Inc., 1937.

Stanford University Bulletin, December, 1936. Annual Report of the President of Stanford University. For the Forty-Fifth Academic Year, Ending August 31, 1936. This being the thirty-third report submitted, to which are appended Annual Reports of the Comptroller, Departments, Committees, and Publications of the Faculty. Paper. Pp. 512. Stanford University: Stanford University Press, 1936.

Medical Urology. By Irvin S. Koll, B.S., M.D., F.A.C.S., Attending Urologist, Michael Reese Hospital. Cloth. Pp. 431, with 92 text illustrations and 6 color plates. Price, \$5. St. Louis: The C. V. Mosby Company, 1937.

A Medical Formulary. By E. Quin Thornton, M.D., Emeritus Professor of Therapeutics in the Jefferson Medical College, Philadelphia. Fourteenth edition, thoroughly revised. Cloth. Pp. 363. Price, \$2.75. Philadelphia: Lea & Febiger, 1937.



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BOOK REVIEWS

Surgical Pathology of the Thyroid Gland. By Arthur E. Hertzler, M. D., University of Kansas. Pp. 298. Philadelphia: J. B. Lippincott Company.

One of a series of monographs by this author. A well-written and illustrated presentation of present knowledge. It is a clinical text that will be of dependable assistance to clinician and surgeon. There is naught to criticize and much to commend because it is up to date.

The Thyroid and Its Diseases. By J. H. Means, M. D., Professor of Clinical Medicine, Harvard University. Pp. 590. Philadelphia: J. B. Lippincott.

This text is an account and record of the experience had in the thyroid clinic of the Massachusetts General Hospital by physicians and surgeons of that clinic staff.

As such it is a useful contribution to the literature. Many special features characterize the text in addition to extended references to all the literature. Clear in description, extended where detail is indicated with sound deductions and conclusions. Doctor Means has compiled a helpful text. Physicians and surgeons will find it to be a frequently used reference.

Medical Greek and Latin at a Glance. By W. R. Agard and C. H. Bunting, M. D. Second edition. Pp. 88. Price, \$1.50. New York: Paul B. Hoeber.

An excellent handbook and guide to commonly used words.

Senile Cataract. By W. A. Fisher, M. D., F. A. C. S., Chicago. Third edition. Pp. 150. Price, \$2.

An honest endeavor to describe this condition and to present operative procedures. Interesting to all eye men.

Ophthalmoscopy, Retinoscopy, and Refraction. By W. A. Fisher, M. D., Chicago. Fourth edition. Pp. 210. Price, \$2.

A practical guide and outline for students and practitioners.

Sexual Power. By C. T. Stone, M. D. Pp. 171. New York: D. Appleton Company.

A casual discussion and little that is new.

Handbook of Orthopedic Surgery. By Alfred R. Shands, M. D., Duke University, in collaboration with R. R. Raney, M. D. Pp. 593. Price, \$5. St. Louis: C. V. Mosby Company.

Fundamentals and principles in orthopedics is the theme of this compilation. It is an index to subjects which will require recourse to more extended texts and references.

Clinical Laboratory Diagnosis. By S. A. Levinson, M. D., and R. P. MacFate, Ch. E. Pp. 877. Price, \$9.50. Philadelphia: Lea & Febiger.

All that one can say of this text is that it consists of a complete description of laboratory procedures for diagnostic purposes. It is a dependable laboratory guide and reference.

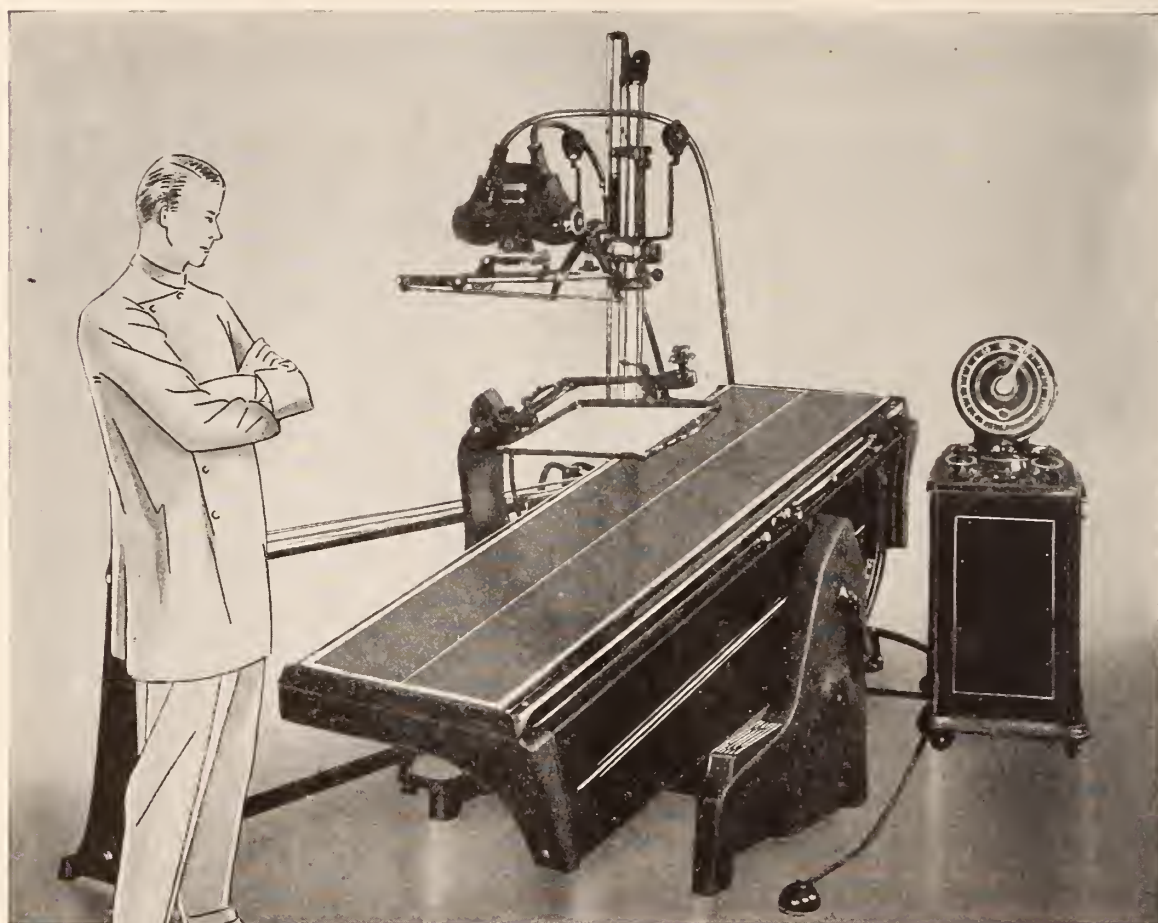
TWENTY-FIVE YEARS AGO

(Continued from Text Page 360)

suria was supposed to have cleared when it was discovered that sugar is secreted after extirpation of the pancreas. The careful study of this gland, which was inspired by Minkowsky's discovery, strengthened the theory that diabetes is due to a destruction of the isles of Langerhans, and an etiologic treatment seemed to be within our reach. . . .

From an Article on "The Blood Pressure in Pneumonia" by F. F. Gundrum, M. D., and E. E. Johnson, M. D., Sacramento.—In spite of the many and great advances in our understanding of the biochemistry of infectious diseases and the marked improvements in the

(Continued on Page 17)



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TWENTY-FIVE YEARS AGO

(Continued from Page 15)

clinical results obtained in some infections by the use of appropriate sera and vaccines, the treatment of inflammatory lesions of the lungs is still largely symptomatic and supporting, no specific therapy being as yet available in combating this group of diseases. . . .

From an Article on "Salvarsan in Cutaneous Syphilis" by Howard Morrow, M.D., San Francisco.—Since December, a year ago, nearly all our salvarsan injections have been given intravenously. A few intramuscular injections of salvarsan in iodipin were given, but this method was found as painful and unsatisfactory as the original suspension for subcutaneous use. The greatest number of injections, given to one person, was in the case of malignant syphilis, reported before this Society last December. This man had two subcutaneous and two intravenous injections. His last injection was given in May, 1911. Since then he has had no symptoms of lues and his Wassermann reaction has remained negative.

The following cases will be reported briefly to demonstrate the various forms of syphilis suitable for treatment with salvarsan. . . .

From an Article on "The Intravenous Application of Salvarsan, with Special Reference to Its Technique" by George W. Hartman, M.D.: From the Genito-Urinary Service of the German Hospital, San Francisco.—Since salvarsan became available we have treated one hundred and one patients with one hundred and eighty injections, mostly in the genito-urinary department of the German Hospital. The largest number of injections given any one patient was seven, the largest amount, three grams. . . .

From an Article on "Alcoholic Injection of Superior Laryngeal Nerve" by H. S. Moore, M.D., San Francisco. This paper is merely a sketch to try to bring out some ideas that have come to me since I have seen the work of Doctor Hoffman of Munich. During the year I spent in his Nose and Throat Clinic I assisted him with his first experiments of alcoholic injections of the superior laryngeal nerve. . . .

San Francisco Polyclinic Society, February 7, 1912.—Dr. Vard H. Hulén described the technique and demon-

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strated the apparatus for doing his operation for extracting a cataract in its capsule, this method having appeared in the July 15, 1911, issue of the *Journal of the American Medical Association*.

Doctor Hulén does not at present select his operation for private patients, owing to the novelty of the principle of using vacuum fixation of the lens, etc., and the as yet unsettled position of the method in ophthalmic surgery. It is hoped that further experience will prove this method suitable for all senile cataracts of any degree of maturity, and superior to any intracapsular operation yet advanced.

It cannot be hoped that the Smith method will be generally adopted in this country or Europe when Major Smith himself says that to do his operation properly the surgeon must first have been trained under his (Smith's) personal direction through hundreds of extractions, and also that an experienced assistant therein is almost as necessary as a carefully trained operator. . . .

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

Good Suggestions for County Medical Societies—Issued by the New York State Society.—1. Improved programs. Interest in the meeting depends largely on the attractiveness of the program.

2. Take up postgraduate course as recommended by American Medical Association. This systematizes the programs.

3. Confer with State Board of Health for at least one meeting a year on public health matters. Coöperation with the Health Department is essential to the welfare of the community.

4. Have at least one reader a year from a distance. Confer with Committee on Scientific Work of State Society if necessary. It will be glad to suggest names of those willing to render such service.

5. Arrange for one or more clinical meetings a year. Select subject and request all who have proper cases to bring them before the Society; then have a discussion on the same, always with the understanding that discussion of the case shall not be held in the presence of the patient; otherwise, frequently patients cannot be shown for obvious reasons.

6. Arrange for demonstrations by bacteriologists and pathologists with specimens, lantern slides, etc.

7. Arrange for social part of meeting. Some light refreshments at the close of the meeting are an adjunct to fraternal intercourse.

8. See that meetings are held often enough to keep up interest. Once or twice a year is not enough. Invite every member of the profession in the county to at least one meeting a year, not necessarily inviting them all to the same meeting. In counties where men do not show a willingness to write papers, either designate writers for different meetings or see that outsiders are invited—in other words, see that the meetings are made interesting. It should be the aim of every county society to secure a permanent home; a small library, with a supply of current

journals, and the use of the larger libraries for reference books, will greatly increase interest in the county organizations.

9. Arrange the time of meeting to accommodate the largest number of members. Where men come from long distances, an evening session is obviously the most inconvenient. An afternoon session will often appeal to a larger number of men when it permits them to reach their home at a seasonable hour.

10. Select as officers men who are willing to work. Keep good men in office. Do not promote those who have shown they will not attend to the duties assigned them. Efficiency is the only criterion of leadership. "No physician should accept office unless he is prepared to give the position the attention that it deserves and unless he is interested in the work."

11. In small societies do not unduly multiply offices—the secretary's and treasurer's duties can be best done by one man. Always supply officers with clerical help if work is onerous. Detailed drudgery work should not be asked of men serving for others without compensation.

12. Make the dues large enough to warrant conducting the Society work in a proper manner. Those who object to the amount of their dues usually do so because they are not receiving full value for them. Give back a dollar in value for every dollar paid in and complaints will be few.

13. Provide a Committee on Entertainment, who shall welcome new or prospective members or guests at meetings. The officers of the Society may be active or ex officio members of such committee. Newly registered physicians should be visited by such committee or written to and asked to join the County Society.

14. See that the meetings, programs, and proceedings are published regularly and promptly in the *State Journal*.

15. Have high ideals. Be liberal yet firm in maintenance of a high ethical standard. Educate the public. Be a power for good in the community. Do not be ashamed of the County Society or apologize for it; make it better. Attend all meetings and see that others do the same. "The County Society is a conservator of patriotism and worthy citizenship."

VITAMIN REQUIREMENTS OF MAN

III. VITAMIN A

• The importance and multiple functions of vitamin A in human nutrition are widely dealt with in clinical literature. Xerophthalmia resulting from severe vitamin A deficiency is rare in this country, yet the etiology of many pathogenic conditions, namely, night-blindness, urinary calculi, lesions of the nervous system, impairment of epithelial tissue and subnormal growth, has been linked with chronic avitaminosis A (1).

Minimum human requirements for vitamin A are influenced by such variables as size of the individual and efficiency of absorption. The minimum daily requirement of infants has been estimated at 1500 International units, based upon the vitamin A content of milk. The need for the vitamin is not supplied by 1200 International units, while 2000 International units appear to be sufficient (2).

Although the minimum requirement of the adult has been estimated to be as low as 500 International units, the optimum level for both older children and adults is probably between 3000 and 5000 International units

per day (3). The League of Nations Technical Commission recommends over 5000 International units of vitamin A for the pregnant and for the lactating woman (4).

Since the human requirement is evidently high, it is fortunate that vitamin A and carotene (pro-vitamin A) are more or less widely distributed in natural foods. Outstanding sources are some of the highly pigmented fruits and vegetables—especially the yellow varieties—and also dairy and marine products (5).

These protective foods, preserved by modern commercial canning, are readily available in all parts of the country throughout the year. It has been repeatedly demonstrated that commercially canned foods retain their vitamin A potency to a high degree (6). The vitamin A potencies of certain commercially canned products have been recently reported in International units (7). From these reports it is apparent that commercially canned foods can be relied upon to supply quantities of vitamin A entirely consistent with the vitamin A of the raw product.

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(1) a. 1935. J. Am. Med. Assn. 105, 1608
b. 1936. Ibid. 106, 996

(2) 1934-35. Am. Pub. Health Assn. Year Book, Page 70.

(3) a. 1934. J. Am. Diet. Assn. 10, 296
b. 1936. Indian J. Med. Research 23, 741

(4) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.

(5) 1933. Chemistry of Food and Nutrition. H. C. Sherman. 4th Ed. Page 364. MacMillan. New York.

(6) a. 1931. J. Nutrition 4, 267
b. 1933. J. Am. Diet. Assn. 9, 295
c. 1936. J. Nutrition 11, 383

(7) a. 1935. J. Home Econ. 27, 658
b. 1933. Georgia Expt. Sta. Bull. No. 177
c. 1936. J. Am. Diet. Assn. 12, 231

This is the twenty-fourth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 360)

department March 8, 1936, on a charge of suspicion of burglary. He was granted three years' probation, with the provision that he make restitution of \$200 as soon as possible. They quote from the report of their officers as follows:

Upon information that the Los Angeles Wholesale Drug Company was losing merchandise over the weekends, we staked out on the place and observed Clark and Co-defendant Beswick drive up in an Essex sedan, belonging to Co-defendant Beswick, observed defendant enter this store and remove seventeen cases of assorted drugs. Apprehended Beswick at Twelfth and San Pedro, and we came back with him and found this defendant Clark hiding behind packing cases upstairs.

Doctor Clark points out:

I was charged with receiving of stolen goods—not burglary. There is a vast difference between these two charges, the charge of burglary being much more detrimental to my character and constitutes felony.

and asks that a correction of the statement appearing in the index above referred to be made. In accordance with the doctor's request, we are glad to state that he was only found guilty of receiving stolen goods and not of burglary.

According to the San Leandro Reporter, March 26, 1937, an impostor calling himself "Dr. Hugh Enright, Dr. Everett Harman, and Dr. Wayne Harvey," has been passing worthless checks on the various merchants of San Leandro. "Captain Henry M. Bradow of the local Police Department yesterday said that communications have been forwarded to the Pittsburgh Police Department requesting information on and pictures of a suspect who was arrested Tuesday for passing fictitious checks in that city. It was reported that the suspect had confessed to passing checks in more than fifty California communities. . . ."

"Jung Shek, one time Chinese herb doctor here, pleaded guilty in the Superior Court today to a charge of having opium in his possession. Judge D. M. Young set April 12 for hearing a report on his probation plea. The man was arrested November 23. . . ." (Stockton Record, March 29, 1937.)

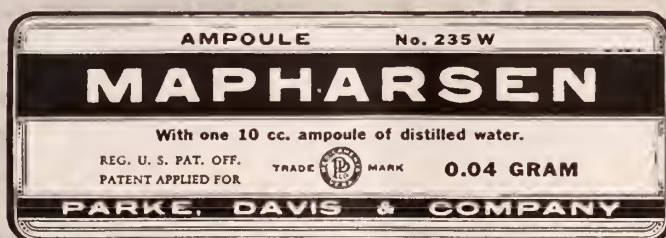
"Charges of conspiracy to perform an illegal operation were on file today against Dr. J. C. Coleman, twenty-nine (colored), Oakland physician. Bail was fixed at \$5,000. Doctor Coleman was arrested on the complaint of Raymond Lombardi, father of Mary Lombardi, nineteen, who died as the result of an illegal operation, according to the police. . . ." (Oakland Post Enquirer, March 30, 1937.)

"Police Chief Louis Belloni of South San Francisco, said today he would investigate the death of Mrs. Mary Shell, twenty-one, who died April 1 of peritonitis. His announcement followed the arrest of the dead woman's mother, Mrs. Yanka Zlataroff, forty-two, on a charge of performing an illegal operation and practicing medicine without a license. Mrs. Zlataroff, police said, admitted having performed two illegal operations, but refused to divulge the names of the women. . . ." (San Francisco News, April 9, 1937.)

"Sheriff Howard Durley reported today that Dr. Jasper J. Mayer, psychologist, recently sentenced to twenty years in Folsom prison, was found in his jail cell with both wrists slashed. Mayer was convicted of having defrauded Mrs. Annie Bateman, Ojai widow, of \$17,000." (San Francisco Examiner, March 26, 1937.) (Previous entry, May, 1936, Adv. p. 18.) No record can be found of anyone by the name of Jasper J. Mayer licensed to practice medicine in the United States.

(Continued on Page 23)

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(Continued from Page 20)

"Dr. Wesley M. Coates, a student at the Sacramento Junior College six years ago, became a martyr to science when he was electrocuted Saturday night in New York by an x-ray machine he had developed to fight cancer. Coates was twenty-nine years old. . . . Coates' machine is capable of developing a million volts of electricity, producing radiation equal to a hundred million dollars' worth of radium. . . . It is believed he accidentally stumbled against the machine while working in his laboratory at the Columbia Presbyterian Medical Center." (Sacramento *Bee*, March 23, 1937.)

"A particular admonition that he must not diagnose, treat or give advice to patients in the future was given to Al Williams, who advertised himself as a 'conditioner of men' yesterday, when he was granted probation by Municipal Judge Arthur S. Guerin on a charge of violating the State Medical Practice Act. Judge Guerin placed Williams on probation for one year and suspended the thirty-day jail sentence." (Los Angeles *Illustrated Daily News*, March 17, 1937.)

"Mrs. Millie Williams, twenty-eight, of 2751 Newell Street, died today after accusing a woman of performing an asserted illegal operation. Following her death, police detectives arrested Mrs. Sarah Hernandez, thirty-three, of 1956 McAllister, who is held on suspicion of manslaughter. Mrs. Hernandez denied she performed the operation on Mrs. Williams. . . ." Los Angeles *Herald-Express*, April 1, 1937.)

"Charging she suffered extreme nervous shock and burns to her left leg when she visited a health institute in Huntington Park, Lela B. Britton had on file a suit

for \$25,000 damages. In her complaint for malpractice, Miss Britton named Rex C. McArthur, Chiropractor, and the McArthur Health Institute, as defendants. The incident occurred, she said, when she was treated with a diathermy machine." (Huntington Park *Independent*, March 25, 1937.)

"The District Court of Appeal today upheld a decision of the San Francisco County Superior Court, denying restoration of a license to practice as a chiropractor to Emerson D. Hartman of San Bernardino." (United Press dispatch, dated San Francisco, March 31, printed in the Los Angeles *Daily News*, April 1, 1937.) (Previous entries, January, March, April, July, September, November, 1935, and January, March, April, 1936.)

"The United States Circuit Court of Appeals' mandate, confirming the conviction in 1934 of Dr. F. T. Cary on narcotic charges, signaled the start of a one-year term for the prominent physician, when he surrendered yesterday to United States Marshal Robert Clark. The mandate also confirmed the conviction of Dr. E. H. Williams, jointly tried with Doctor Cary. Doctor Williams has been placed on probation for five years. The two physicians were convicted of issuing prescriptions for quantities of morphin, ranging from 22 grains in one prescription to 60 grains in another." (Los Angeles *Illustrated Daily News*, March 25, 1937.)

"After judgment had been rendered in favor of Ellene Kelleck, whom he was suing, Dr. S. G. Sonneland, former Pasadena physician, assertedly grabbed the woman as the two left the courtroom in the Justice Court this morning, and began shaking her, drawing upon himself arrest on two counts, assault and battery. He pleaded guilty and waived a jury trial, was fined \$50 and \$25 on each of the

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

two counts, the sentence suspended for two years by Judge William E. Fox. Records revealed that he formerly had sued Miss Kelleck for the same purpose, a \$50 bill, in the Los Angeles court, which also gave judgment in her favor. Deputy Constable W. E. Stevens arrested the man, handcuffing him until order was restored." (Pasadena *Star News*, April 2, 1937.)

"The gates of the California State Prison at San Quentin opened Tuesday of last week to release Dr. M. J. Marmillion, principal in a tragic nationally famous abortion case back in 1933, it became known here this week. After four years' incarceration, Doctor Marmillion, former practicing physician at 3311 Central Avenue, was paroled to Dr. E. A. Mitchell, local pharmacist, for a period of ten years. The doctor was sentenced in June, 1933, to from five years to life imprisonment in the penitentiary for second-degree murder. . . ." (Los Angeles *Eagle*, April 2, 1937.) (Previous entries, April, August, November, 1933; February, 1934.)

The Texas Board of Medical Examiners reports an alleged impostor named Harold William Bradshaw is assertedly using the name of a licensed Texas physician named Bedford F. Floyd. The report indicates that this impostor has a criminal record.

John David Dunlop, reputed "habitual violator of the Medical Practice Act," was reported arrested by Acting Assistant Special Agent Anderson of the Los Angeles Investigation Department of the Board of Medical Examiners, March 25, and arraigned before Highland Justice of the Peace J. W. Moore, who sentenced him to 180

days in the county jail. Dunlop thereafter, on the twenty-ninth day of March, pleaded guilty before Justice of the Peace P. G. McIvor, Redlands, and was again sentenced to 180 days in the county jail, said sentence to run concurrently with the Highland sentence. Reports indicate that Dunlop had been arrested four times since 1928 on other charges. (Previous entry, February, 1935.)

Report filed by Acting Special Agent John R. Ronan, Los Angeles office of the Board of Medical Examiners, states that Levon Garabed Kassabian, M.D., was on April 2, 1937, arrested in Los Angeles on a warrant issued August 31, 1936, charging violation of the Medical Practice Act.

United States post-office inspectors recently reported the arrest on March 6, 1937, in Nashville, Tennessee, of Raymond B. Hall and Ernest Mandell, both assertedly charged with misuse of the mail as alleged eyesight swindlers; Raymond B. Hall to be removed to Norfolk, Virginia, to stand trial on an indictment in connection with the swindle of Roberta M. Ridley of Boykins, Virginia, and Mandell for removal to Milwaukee, Wisconsin, in connection with the swindle of Hermann Volker of Ripon, Wisconsin. Ernest Mandell's removal will be delayed because of his attempted suicide in the jail following his arrest, he having been reported to have dived from the third-floor balcony to the first floor, resulting in serious injuries. Reports also indicate that James Henry Howard, alias Jimmy Head, William Sacks, Susie Sacks, and Edward Robinson, all indicted for misuse of the mails in connection with the alleged swindle of Lucy Finger of Stanley, North Carolina, have been apprehended by federal authorities. Edward Robinson on March 15, 1937, was given a two-year sentence. Roy L. Martin, apprehended in Los Angeles, Curtis Yeager and Jack Holtkamp, all charged with fraudulent use of the mails in

(Continued on Page 26)



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(Continued from Page 24)

connection with the swindle of Mrs. S. E. Fifield, Remington, Virginia, were given penitentiary sentences.

Theodore Jacobsen, on March 15, was reported to have pleaded guilty in the Los Angeles court to a charge of violation of the Medical Practice Act and on March 22 was sentenced by Municipal Judge LeRoy Dawson to pay a fine of \$250 or serve 180 days in the city jail, the sentence being suspended on condition the defendant cease using the suffix "M. D."

Theodore H. Niemann, M. D., placed on five years' probation on March 7, 1933, after a hearing before the California Board, based upon narcotic addiction, according to the records was arrested in Denver, Colorado, January 4, 1937, and sentenced to six months in the county jail because of narcotic derelictions.

There is no royal road to reconstruction for a failing heart; but by knowledge and perseverance, interest can be stimulated in something which will often successfully restore a person to usefulness and rescue him from invalidism.

Bad Foods Under Fire: Federal Officials Seize Larger Quantities of Unfit Merchandise.—Insect damage, infestation, mold and decomposition in canned vegetables, fruits and seafoods, and in frozen eggs, fresh fish and nuts placed these commodities at the head of recent seizures under the Food and Drugs Act, the Federal Food and Drug Administration reports. Economic frauds, represented by weight shortage or the unannounced substitution or abstraction of ingredients, ran second in importance. The presence of poisonous contaminants was the least conspicuous violation of the law uncovered.

Poisonous Adulterants in Foods.—Poisonous adulterants account for the remainder of food seizures. They were: 25 bushels of apples bearing arsenic and lead residues, 548 sacks of lima beans containing lead, and 342 pounds of crude edible gelatine containing arsenic.

Continuation of the work on surgical dressings brought the seizure of 3,150 packages of absorbent cotton, 336 packages of gauze bandage, and 28,200 envelopes of an "adhesive compress," all found to be unsterile although labeled "sterilized." Four boxes of surgical catgut sutures, likewise unsterile, also were picked up.

Other drug items seized were: 1,860 bottles of low-strength tincture of iodine, 168 cans of impure anesthetic ether, 69 bags of jalap root found to vary from the official variety, 632 bottles of below-standard aspirin tablets, labeled "100" per bottle, but with an average of only

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ninety-one per bottle; 623 bottles of so-called rubbing alcohol made up principally of isopropyl alcohol.

One shipment each was seized of "Cereal Lactic," represented as a good source of lactobacillus acidophilus although in fact practically inert, and "Hygem Mineral Oil Emulsion with Acidophilus," found to contain only negligible numbers of lactobacillus acidophilus, and contaminated with large proportions of other microorganisms.

Patent Medicines Seized.—The following patent medicines were seized under the authority of the Food and Drugs Act, on allegations that claims made for the treatment of the disease conditions named below were beyond the capabilities of the articles:

"Dr. Brigadell's Camphorole," petrolatum and lanolin with volatile oils, and "Dr. Brigadell's Camphorole Nose Drops," liquid petrolatum with essential oils, represented as a treatment for nasal irritations, irritation of the bronchial tubes, acute hoarseness, chronic rheumatism, aching feet, itching piles, tired nerves, skin irritations, throat irritations, and colds and coughs in dogs.

"Cadum Ointment," consisting of 20.4 per cent zinc oxid, 4.6 per cent sulphur, with salicylic acid, oil of cade, petrolatum, and wax, the label of which declared 13.25 per cent zinc oxid and 8.98 per cent sulphur, offered as a treatment for eczema, pimples, pustules, blotches, warts, inflammation, skin diseases, ulcers of the skin, boils, piles, and scalp diseases in children.

"Chambers' Pills," containing potassium nitrate, potassium carbonate and plant drugs including buchu, coated with green-colored calcium carbonate and sugar, for backache, weak back, rheumatism, dropsy, congestion of the kidneys, inflammation of the bladder, urinary trouble, gallstones, gravel, diabetes, Bright's disease, and leukorrhea.

"Colac Pile Pills," containing magnesium oxid, plant extracts and a tar-like material, coated with sugar, chocolate, and iron oxid, for relief from piles in twenty-four hours; "Dunlap's Colic Remedy for Horses and Mules," consisting of 50 per cent alcohol, with water, ether, ammonia, camphor, nitrite, and plant extracts, including asa-fetida, for colic and gravel, and to strengthen the digestive organs of live stock and give appetite.

"Fairey Oil," turpentine and wintergreen, colored green, for neuralgia, rheumatism, toothache, headache, stiff neck, lame back, sore throat, cold in the chest, pains in the head, side, stomach, feet, limbs and shoulders, cramps, colic, hacking cough, bunions, stiff joints and muscles, flu and fever.

"Dr. Gram's Grandmother Medicine," powdered plant material containing aloe, an emodin-bearing drug and ginger, for blood, liver, kidney and stomach diseases, rheumatism, chills, fever, malaria, dyspepsia, sick or nervous headache, scrofula, neuralgia, biliousness, constipation, palpitation of the heart, erysipelas, syphilitic troubles,

(Continued on Next Page)

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★ *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60



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 No. 11, 590; *Laryngoscope* 1935 XLV,
 149-154. *Proc. Soc. Exp. Biol. and Med.*,
 1934, 32, 241-245. *Laryngoscope*, 1937,
 XLVII, 58-60.

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(Continued from Preceding Page)

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"Malto-Hopo Herb Phosphate Health Beverage," a brown-colored liquid containing sugar and plant extracts benzoic acid 0.6 per cent of inorganic compounds including phosphates, but represented as containing "phosphates, herb phosphates and acid phosphates, including those of lime, magnesia and soda," which were in fact insignificant, offered for toning the stomach and nervous system, inducing refreshing natural sleep, invigorating the nerves, promoting digestion, and for indigestion, nervous dyspepsia, wakefulness, headaches, mental or physical exhaustion, insomnia, severe colds, nervous chills, and to overcome the liquor, tea, or coffee habit.

"R-P 60 Bladder and Gland Remedy," a water extract of plant drugs including a laxative and some salicylate, for ailments of the prostate and bladder; "Ra-Ed-O Pile Suppositories," cacao butter with small amounts of quinin, salicylates, iron compounds and sulphates, not antiseptic as represented, and offered as a treatment for piles.

"Rozel Douche Powder," boric acid, sodium chlorid, ammonium alum and small proportions of phenol and menthol, for inflammations, irritations, leukorrhea, itching, and minor hemorrhages; "Rozel Effervescent Cones," containing tartaric acid, sodium bicarbonate, talc, starch, and a chlorin-liberating compound, falsely represented as germicidal, for the relief of inflammation, and as a protection against social diseases.

"Sasa Scalp and Skin Hair Tonic," water and alcohol, containing borax, caramel and oil of cinnamon, for dandruff, falling hair, eczema and itchy scalp; "Summus,"

APPROVED CLINICAL PATHOLOGISTS

American Medical Association Essentials for An Approved Clinical Pathologist

An approved clinical pathologist should be a licensed graduate of medicine. He shall have specialized in clinical pathology, bacteriology, pathology, chemistry, and other allied subjects for at least three years, and he should be reasonably familiar with the manifestations of disease in the body. The director of a clinical laboratory shall be on full time or have definite hours of attendance, devoting the major part of his time to this specialty. A clinical laboratory is an institution organized for the practical application of the fundamental sciences by the use of specialized apparatus, equipment and methods, for the purpose of ascertaining the presence, nature, source, and progress of disease in the human body.

The following Clinical Pathologists directing private laboratories in California are approved by the Council on Medical Education and Hospitals of the American Medical Association:

**Clinical Laboratory of Drs. W. V. Brem, A. H. Zeiler, Roy W. Hammack
and G. D. Maner, 657 So. Westlake Avenue, Los Angeles, California.**

Zera E. Bolin, M.D., 490 Post Street, San Francisco, California. ✓ ✓ ✓

These laboratories use standard methods and are fully equipped to make all clinical examinations of recognized value in: Tissue Pathology, Bacteriology, Hematology, Serology, Bio-Chemistry, Kolmer Wassermanns, Kahn test, Medico-legal, Basal metabolism, Blood chemistry, Hormone Test for Pregnancy, Parasitology, Cardiology, Autogenous vaccines, etc.

Mailing containers sent on request. Special delivery postage insures prompt, accurate service.

water, alcohol, borax, sodium bicarbonate, small amounts of a zinc compound, color and flavor including cassia, for tonsillitis, nasal catarrh, and spongy and bleeding gums.

"Verified Magnesia Dental Cream," bearing a statement alleged to create the impression that the product had been tested and approved by some branch of the United States Government, the product being further alleged misbranded in that it was offered for the prevention of decay, and as a "triumph in mouth, teeth and gum prophylaxis," regarded as being beyond the capabilities of a tooth paste; "Victory Vapor Balm," an ointment containing camphor, menthol, eucalyptol and pine oil, for hay fever, catarrh, influenza, asthma, croup, whooping cough, quinsy, sore throat, bronchitis, tonsillitis, and cold in the head.

"Wah-Poo-Sah Kee-Kee-Kee," water and alcohol with small proportions of plant extractives and a plant laxative, for activating the muscles of the bowels, and for building up the blood; and "Zonalife," Epsom salt in water, with small amounts of iron and sodium compounds, salicylic acid, wintergreen and saccharin, for indigestion, headaches, sluggish kidneys, rheumatism, and high blood pressure.

Cases Terminated

Actions brought against shippers under the criminal provisions of the Federal Food and Drugs Act were terminated as follows: Zo-Ro-Lo, Inc. (a firm operated by Ralph Runyan and Charles Collett), Ada, Ohio, shippers of "Zo-Ro-Lo," a solution of Epsom salt in water, with glycerin, benzoic acid, citric acid and menthol, colored red, offered as a treatment for ailments traceable to intestinal auto-intoxication, to insure proper elimination, and for indigestion, fine \$50 and costs.

Keystone Laboratories, Inc., Memphis, Tennessee, shippers of "Keystone Rx 4344," "Ruherb Tonic," "White Pine Compound Expectorant," variously offered for the relief of kidney and bladder ailments, indigestion, torpid liver, backache, rheumatism, coughs and bronchial affections, fine \$300 and costs.

For shipments of below-standard pharmaceuticals, Armour & Company, Chicago, Illinois, \$25 and costs; Standard Pharmacal Company, Chicago, Illinois, \$50 and costs; Cumberland Manufacturing Company, Nashville, Tennessee, \$200; Warren-Teed Products Company, Columbus, Ohio, \$800; Columbus Pharmacal Company, Columbus, Ohio, \$1,200; and A. E. Mallard, Detroit Michigan, \$4,800, fine suspended and defendant placed on probation for five years.

P. R. Bodle Company, Seattle, Washington, insect-infested and wormy raspberries, fine \$50 and costs; Robinson Canning Company, Robinson, Arkansas, tomato juice made from moldy material, \$75 and costs; Scotty Packing Company, Cordova, Alaska, partially decomposed canned salmon, \$25 and costs; Malvern Cold Storage Company, Malvern, Iowa, diseased and decomposed poultry, \$25 and costs; Robinson Canning Company, Robinson, Arkansas, canned spinach containing worms, insects, and extraneous filthy material, \$50; and Libby, McNeill & Libby, San Francisco, California, dirty dried peaches, \$200.

Summer Diarrhea in Babies.—Casec (calcium caseinate), which is almost wholly a combination of protein and calcium, offers a quickly effective method of treating all types of diarrhea, both in bottle-fed and breast-fed infants. For the former, the carbohydrate is temporarily omitted from the twenty-four-hour formula and replaced with eight level tablespoonfuls of Casec. Within a day or two the diarrhea will usually be arrested, and carbohydrate in the form of Dextri-Maltose may safely be added to the formula and the Casec gradually eliminated. Three to six teaspoonfuls of a thin paste of Casec and water, given before each nursing, is well indicated for loose stools in breast-fed babies. Please send for samples to Mead Johnson & Company, Evansville, Indiana.

Better keep yourself clean and bright; you are the window through which you must see the world.

Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$—— to be known as the —— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$——, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the —— Gift, the following described real property situate in the County of ——, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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(dibrom-oxymercuri-fluorescein-sodium)



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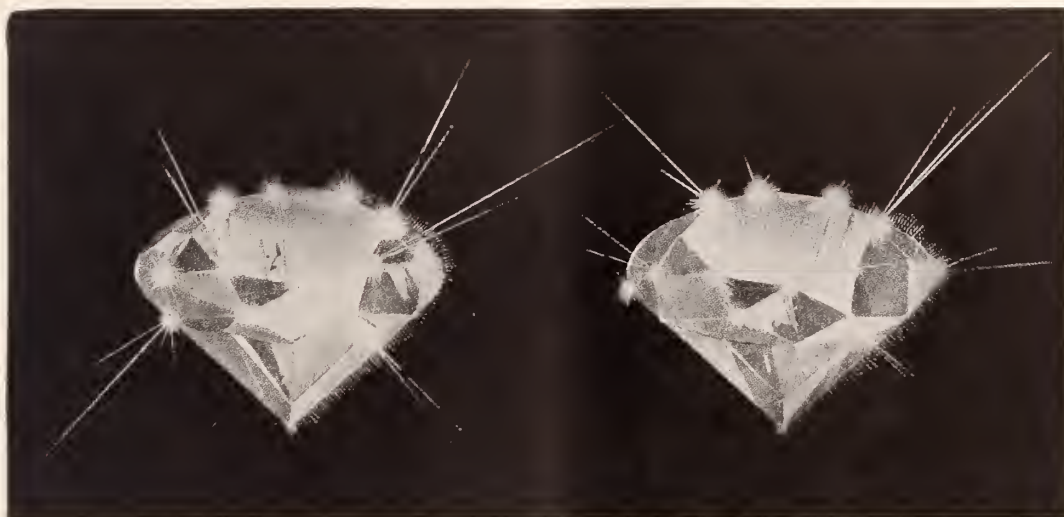
Thirteen years' acceptance by the Council of Pharmacy and Chemistry of the American Medical Association

A booklet summarizing the important reports on Mercurochrome and describing its various uses will be sent to physicians on request.

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BALTIMORE, MARYLAND

Vitamin Deficiency in Diets in Diabetes.—Sindoni investigated the diets of eighty-five diabetic patients, who suffered also from disturbances involving the gastrointestinal, genito-urinary, gynecologic and cardiovascular systems, as well as the visual field and oral, neurologic, skin, joints and endocrine glands. The patients were obese; 5.4 per cent suffered from gangrene and 3.5 per cent from malignancy. They were still ignorant of the true nature of their condition—a factor in the causation of increased diabetic complications and mortality. They were on restricted diets, but none adhered to their prescribed diets. Avitaminosis and hypovitaminosis were found in every one of the patients. These disturbances were not the result of one vitamin but of several, as amply evidenced by the patient's dietary history, symptoms and physical disturbances. Many physicians adjust insulin dosage to the carbohydrate allowance only, disregarding proteins, fats, vitamins and other elements of diet. There was a marked correlation in vitamin-deficiency diets to the rise in the incidence of diabetes, diabetic complications or concurrent diseases, but no correlation in overeating. These observations determined the author to correct the diet of these patients. He strongly advocates a more detailed study of the patient's diet history as well as of the symptomatology. The diabetic patient's diet should consist of natural foods, rich in the essential vitamins and other elements, since such diet will more often result in greater adherence by the patient to his instructions. The following advantages will be obtained: (1) better coöperation of patient with physician; (2) less complications, symptoms or physical disturbances; (3) less insulin; (4) better metabolic equilibrium; (5) better outlook on life; (6) prolongation of the span of usefulness; (7) greater resistance to infection; (8) avoidance of avitaminosis and hypovitaminosis; and (9) more energy. Diets consisting of a variety of natural foods, such as vegetables, fruits, milk and its products, meat and cereals in prescribed proportions, with hygienic measures, such as sunshine, fresh air and exercise, will result in little need to worry about vitamin deficiency in diabetes.—*Journal A. M. A.*



THEY LOOK ALIKE

BUT THERE'S A BIG DIFFERENCE

Two diamonds, side by side . . . each has dazzling brilliance. To the average purchaser they seem identical. But only one is perfect; the other's value is far less because of carbon flaws. Yet only an expert can detect the difference.

The ordinary purchaser has no way to tell a fully potent vitamin product from a deficient one, either. They may look alike . . . weigh, taste and smell the same. Only an expert with elaborate equipment can measure true vitamin content.

Realizing this and knowing, too, that deficient vitamin products are sold, many careful physicians protect their patients by prescribing

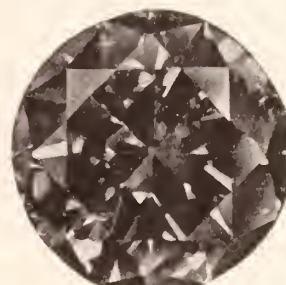
Haliver Oil with Viosterol and specifying Abbott in writing whenever vitamins A and D are indicated.

Your confidence in Abbott vitamin products is warranted because of the rigid bio-assays, elaborate equipment and beginning-to-end control of production Abbott maintains in manufacture. Prescribe routinely for growing children, expectant and lactating mothers and all others who require additional vitamins A and D. Available at prescription pharmacies everywhere in soft, tasteless, 3-minim capsules in boxes of 25, 50, 100 and 250. Also in 10-cc., 20-cc., and 50-cc. vials with droppers.

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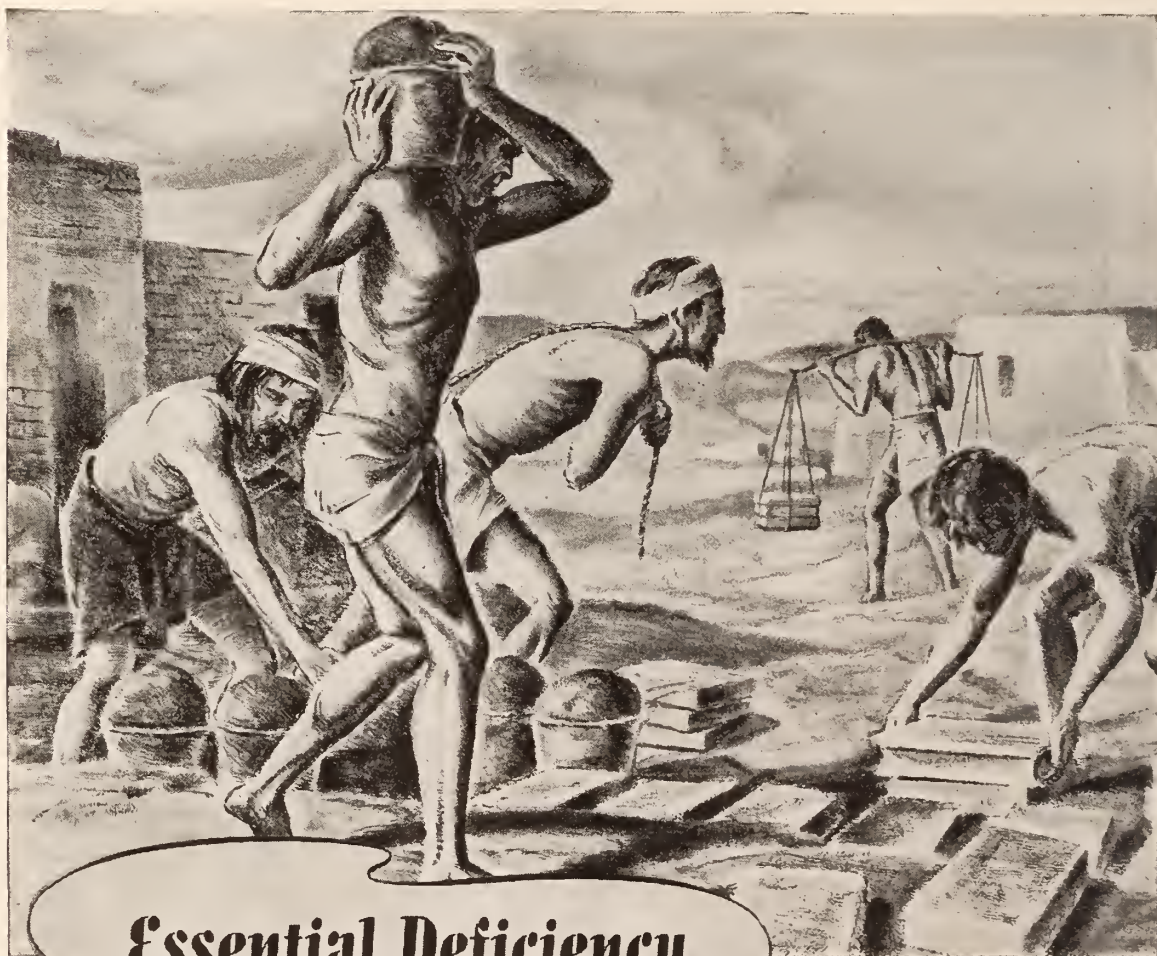
A-5-37

Please send me FREE SAMPLES of Abbott's Haliver Oil with Viosterol capsules and vitamin literature.

M.D.

Address _____

City _____



Essential Deficiency in Pernicious Anemia

"Bricks without straw"—more practicable than adequate treatment of pernicious anemia without the antianemic material such as is contained in liver.

● The essential nature of pernicious anemia appears to be a nutritional deficiency. Such "building stones" as are required for normal red blood cell formation are available to the blood-forming organs only in less than optimal amounts. These deficient elements may be supplied by adequate liver therapy.

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anemic material contained in liver assures utilization by the body of the necessary anti-anemic substance.

Solution Liver Extract Concentrated, Lilly, is supplied in 10-cc. rubber-stoppered ampoules and in packages of four 3-cc. rubber-stoppered ampoules.

Solution Liver Extract, Lilly, is supplied in 10-cc. rubber-stoppered ampoules.

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CALIFORNIA AND WESTERN MEDICINE

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EDITOR GEORGE H. KRESS

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Advertising Representative for Northern California
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Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles; Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

C. M. A.'S SIXTY-SIXTH ANNUAL SESSION

President Edward M. Pallette Becomes Past President: President-Elect Howard Morrow Assumes Office as President.—The current, May issue of CALIFORNIA AND WESTERN MEDICINE will be in press while the meetings of the sixty-sixth annual session of the California Medical Association are being held, so that it will not be possible, through the printed page, to give convention news other than the Addresses of the Retiring and Incoming Presidents. Component county societies should, therefore, ask their delegates to make reports at the May meetings. Comments on the proceedings and official minutes will appear in the June number of the OFFICIAL JOURNAL.

On the evening of Wednesday, May 5, Dr. Edward M. Pallette of Los Angeles, former Speaker of the House of Delegates and, during 1936-1937, president of the California Medical Association, will have laid down the responsibilities of the presidential office, his place being taken by the president-elect of last year, Dr. Howard Morrow of San Francisco. In expressing appreciation of the services which the retiring president, Doctor Pallette, has rendered to organized medicine in the years gone by, the Association turns to welcome his successor, Doctor Morrow of San Francisco, whose faithful performance of duty on the professorial staff of the University of California's Medical School and as president of the California State Board of Health, is ample warrant, as he takes up his new work, of a successful administration to come.

* * *

President-elect is Dr. William W. Roblee of Riverside.—There cometh also unto us, in a different rôle than has been his in the recent past, a new president-elect, who is none other than Dr. William W. Roblee of Riverside, California, a graduate of Cooper Medical College, Class of '95, and who, as a laborer in the vineyard of organized and scientific medicine, has long enjoyed the highest esteem of colleagues from all portions of the State. He gives up his duties as Speaker of the House to assume new responsibilities, and how well he will fulfill these with credit to himself, his

†Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

many friends know. The Association, therefore, extends to him its congratulations and good wishes.

In the June issue, full reports of the 1937 annual session meetings will be given.

DENTAL SURVEY OF SAN FRANCISCO ELEMENTARY SCHOOL CHILDREN: A COMMENDABLE REPORT

Facts Concerning the Dental Survey of San Francisco Elementary School Children.—Recently there came into our hands a copy of the "Dental Survey of San Francisco Elementary School Children," a Federal Works Progress Administration (WPA) project, having, as its legal or public sponsor, the San Francisco Department of Public Health, through Dr. J. C. Geiger, and, as its contributing or co-sponsor, the San Francisco Dental Society, through Dr. Ernest Sloman, Survey Director. This survey, conceived in November, 1933, was put into operation on August 17, 1934, and the report, brought off the press in October, 1936, was carried out under the supervision of James B. Sharp, Ph.D., Coördinator of Statistical Projects in California; the final summary making a compact brochure of twenty-one pages of text, tables and graphs, set up in typewritten form.

* * *

Why Attention Is Called to It.—Attention is called to this report for several reasons: first, because it is in line, regarding contents and presentation, with what one would expect from such a survey report; secondly, because the California Medical Association, as co-sponsor of the California Medical Economic Survey, has itself already had an expensive and unpleasant experience in a work project of somewhat similar nature which, with the California State Board of Health, it took up in good faith, only to see its search for accurate knowledge concerning sickness costs of California citizens take on controversial sidelights because of the improper orientation of one or more lay individuals, whose services had been engaged to supervise the collection and compilation of the statistical information gathered by the clerical force and field workers; these misguided persons seemingly being under the impression that they were the beginning and end of the survey, instead of only being hired to do supervisory work and statistical compilation that would establish factual data from which the legal sponsor (the California State Board of Health) might indicate its interpretations and conclusions. It is quite possible that at the California Medical Association Del Monte session (only two weeks away) the matter will be discussed, and that delegates will be able to carry back to the component county societies the story of how thirty-five thousand dollars of the Association's funds were expended by its appointed lay experts, and what kind of report is at last being submitted in manuscript form.

What Was Done With a Bulky Report.—Several paragraphs in the Dental Survey report, here referred to, may indicate why it was carried through to successful completion with fair promptness; the opinions expressed being worthy of reflection, when one would consider the delays which were met with in the California Medical Economic Survey:

A great deal could be written regarding dental infection, the nature and importance of caries, diet, dental research, preventive dentistry, and other related problems, *but this formal report is intent upon one major problem, i. e., reporting what was found on this federally subsidized survey as clearly and as briefly as possible. . . .* (Italics our own. Editor.)

* * *

A preliminary bulky report prepared by the project supervisor, Mr. Harries, was submitted and has been completely redrafted (Parts A and B) by Dr. James B. Sharp, Coördinator of Statistical Projects for the Works Progress Administration in California. In this report only such data are utilized as were tabulated on the project. The concluding remarks appearing in Part C were prepared by Dr. Ernest Sloman. . . . (Italics our own. Editor.)

* * *

Significance of Dental Caries in Childhood.—From the concluding remarks by Ernest Sloman, D.D.S., the following significant comments on facts elicited by this survey of San Francisco school children are also worthy of consideration by dentists, physicians and the public:

The problem of dental caries is a challenge to civilization. Unless and until science develops a preventive formula or an individual whose contribution to mankind has the same effect on our fight against caries (as did Jenner's discovery on the prevention of smallpox), we can use only those measures afforded by dental science to eliminate or control the most prevalent, and by far the most expensive disease that man knows of today. A careful study of the disease and the facilities available in civilized countries for its control, indicates that the disease can be controlled. The tardiness with which these facilities are employed is nearly wholly responsible for a devastating waste of our most precious possessions, health and vitality. . . .

* * *

We can make little or no progress towards increasing the percentage of American people with clean, healthy mouths, until the people, as well as the profession, learn and appreciate that the investment of comparatively small amounts of time and money for dentistry during childhood and youth adds years of health and comfort and, in most instances, eliminates the necessity for large and costly dental restorations in middle life and during the years of decline of physical vitality. . . .

* * *

The control of dental caries, which is probably the most expensive and extensively devitalizing disease that mankind has today, lies in promoting public appreciation of the following facts: (1) that the cost of dental care for the individual can be reduced by providing early and adequate attention to the teeth, and (2) that, although dental caries is apparently a localized disease of childhood and youth, it is a primary or initial lesion involving painful, expensive, lingering or protracted diseases of old and middle age. . . .

* * *

Federal WPA Instructions Which Should Have Been Observed in the California Medical Economic Survey.—Before leaving this subject, attention may likewise be called to a letter, dated March 22, 1937, sent by Dr. James B. Sharp, Coördinator of Statistical Projects, to the Direc-

tor of the Survey to the preparation of which the California Medical Association gave \$35,000 support as a coöperating sponsor; because, in that letter some important rules are laid down, which, had they been observed in California, would in all probability have done away with the confusion and delay (in part occasioned through the attempt by the Director to secure a copyright), which thus far has kept from publication this State Board of Health-California Medical Association "California Medical Economic Survey" as a completed project. We quote:

Under date of March 13, the Works Progress Administration, Washington, D. C., has issued Operating Procedure No. W-11—"Regulations for Publication of Statistical, Survey and Research Materials." One or two of the sections in that Operating Procedure will be of interest, and give you the latest information that we have on the subject. . . .

Section 3. Within a reasonable time after completion of a study, the Works Progress Administration shall be provided with at least ten copies of the final report. In most studies, the report should include the following sections:

- Scope
- Objectives
- Methodology
- Findings and Conclusions.

. . . In the publication of statistical, survey and research material, the sponsoring agency [California State Board of Health, for the California Medical Economic Survey] shall be responsible for any interpretations or conclusions made from data collected on the work project. . . .

Section 6. Data secured or reports published from studies financed in whole or in part by funds allotted to the Works Progress Administration are intended for public use. Copyrighting of any such statistical, survey and research material by an individual or organization, public or private, shall not be sought. . . .

Subsequent to the receipt of Coördinator Sharp's letter of March 22, quoting the WPA's bulletin of March 13, 1937, in which operating rules for projects such as the California Medical Economic Survey were outlined (some excerpts are given above), a letter of date of April 12, 1937 was received from the Director of the California Medical Economic Survey (who had previously received a copy of the March 13 rules laid down by the central authorities at Washington), and in this letter the Director of the California survey again outlined a list of stipulations, of such nature as to indicate his inability or unwillingness to understand the instructions from the Washington office. From this later letter of April 12 we quote only one item (leaving to our readers the right to imagine the other contents of his communication). Section 5 of his letter of stipulations reads:

5. It is agreed that final authority for any and all changes in the report as submitted by Dr. Paul A. Dodd shall rest with Doctor Dodd himself, as Director of the Survey.

From all of which the members of the California Medical Association may again remind themselves of the old saw,

Experience is the best teacher.

TWO IMPORTANT ANNUAL-SESSION PAPERS: ONE BY RETIRING PRESIDENT PALLETTE, AND THE OTHER BY PRESIDENT MORROW*

In this issue of CALIFORNIA AND WESTERN MEDICINE appear two of the addresses given at the general meeting of the California Medical Association's recent Del Monte session, and, since each paper deals with important subjects, the facts and opinions expressed by these ranking officers are worthy of every member's most careful reflection.

Some of the thoughts to which Doctor Pallette gives expression will be startling, and to a few readers, perhaps, unacceptable. Nevertheless, his arguments, based on demonstrated scientific knowledge and historical records of civilization are such that counter-statements of equal force and value will be most difficult to find. Portions of the picture, too, which Doctor Pallette outlines are not pleasing to contemplate but physicians, as members of a scientific and learned profession, would reflect no credit upon themselves by refusing to acknowledge the existence of trends which our Retiring President so courageously has brought into the open for our joint and individual consideration.

President Morrow's paper, on the other hand, discusses governmental ways and means of combating the deplorable results of syphilis and gonorrhea; diseases which, together, have been and still are among the most potent of all causes that make for a devitalization of the human race. At the present time, and in overabundance, we are being subjected to almost superbuoyant "alpha-to-omega" solutions of problems connected with these two scourges, whose wide prevalence has been so fully demonstrated; the two diseases, in both medical and lay circles, having too long been cloaked with a covering of secrecy and hypocritical modesty. Now that federal moneys will be brought into the battle against syphilis and gonorrhea, it should be possible to bring about new and more successful alignments to eradicate the dreadful maladies. Because the Federal Government is obligated to work through a constituted commonwealth authority, such as a state board of health, and since active governmental participation in plans to make the diagnosis and treatment of venereal diseases available to all citizens necessarily implies private practice modification of procedures in the handling of these transmissible diseases, it is important for members of the medical profession in this State to orient themselves concerning the present and possible future activities of the Board of Health of the State of California in the great fight. Doctor Morrow's message, therefore, has special value, not only through his standing as professor of dermatology and syphilology at the University of California, but because he is also president of the California State Board of Health, the agency through which the newer procedures must be transmitted to local health officials and the profession at large.

We again commend to our readers the perusal of these two suggestive and important papers.

* Doctor Pallette's paper appears on page 296; Doctor Morrow's on page 300.

"AMERICAN MEDICINE": TWO VOLUMES OF REAL VALUE

Extensive Literature on Sickness Costs.—Discussions of medical relief problems, in both medical publications and the press of recent years, have brought to the attention of physicians volume after volume, and also many articles, seemingly without end. In the beginning the temptation to purchase each work presented was naturally great; but this desire lessened as the inadequacy of the printed material made itself evident. Indeed, were it not for the importance of the subject, and the prominence given to it in public-welfare propaganda, together with the hope that a forthcoming publication might outline a clearer or a better solution of some of the problems involved, one would be inclined to abstain from adding such book and magazine literature to a library.

* * *

"American Medicine" has 2,200 Physician Contributors.†—It is, therefore, refreshing to be able to call attention to a scholarly work of some 1,435 pages, entitled, "American Medicine: Expert Testimony Out of Court,"* edited and published by the "American Foundation," 565 Fifth Avenue, New York, and issued in two large, well-printed volumes, presenting compactly and in an interesting manner, reports, in the form of letters, from some 2,200 representative physicians of the United States; many of the comments dealing with the present status of American medicine, and also the much-discussed subject of ways and means for securing adequate medical care to all citizens, no matter what may be their social or economic position.

These contributors hail from every state of the Union, and represent all divisions of general prac-

tice, the specialties (both urban and rural), and medical education. In securing the information so compiled, six letters of inquiry were used: one going to men of twenty years or more in medical practice; a second to recent graduates; a third devoted to medical education; a fourth bearing on group practice; a fifth dealing with standards of surgical practice; the sixth covering group hospital insurance.

* * *

Scope of the Report.—The scope of the report may be better appreciated by noting the subjects considered, some of which include:

What is "adequate" medical care?

Is the cost of it the only reason why it is not generally available?

How much modern scientific medical care of high grade exists at all?

If it were "available" now to all, would a large part of the population still choose quacks, cults and patent medicines?

How far is government responsible for the health of the individual?

What part should government have in promoting public health and providing medical service?

Who should pay for the medical care of the indigent sick?

Is the old line of demarcation between preventive and curative medicine any longer practicable or desirable?

Is improving medical education and the personnel of the medical profession the first step in improving the organization and distribution of medical care?

Is there too much specialization?

Can an individual doctor really furnish scientific medical care alone, or are organized laboratory and consultative assistance an absolute necessity?

In the medicine of the future will the practitioner function as an individual or as a member of a group?

What is the present status of the family doctor—is he "passing"; or is a new version of him just coming into being?

Is the "doctor-patient relation" an absolute sentimentality or has it a practical value in modern scientific medicine?

Is there too much surgery?

* To be obtained from the publisher at the price of \$3.50.

† The 2,200 contributors include the following California physicians:

Abbott, F. P., Ontario
Adams, Ben O., Riverside
Adams, Lemuel P., Oakland
Anderson, A. E., Fresno
Barrow, William H., San Diego
Beckh, Walter, Berkeley
Birnbaum, Walter, San Francisco
Blomfield, A. L., San Francisco
Boardman, W. W., San Francisco
Boonschaft, Louis, Los Angeles
Brown, Philip King, San Francisco
Bumpus, Jr., H. C., Pasadena
Burger, Thomas O., San Diego
Chaffin, Rafe C., Los Angeles
Chapman, John F., Pasadena
Chapman, V. A., Los Angeles
Cheney, William F., San Francisco
Chipman, Ernest D., San Francisco
Clarke, R. Manning, Los Angeles
Coffin, Harry Welrose, Los Angeles
Compton, C. S., Bakersfield
Condit, Joseph D., Pasadena
Cummings, Roland, Los Angeles
Dock, George, Pasadena
Doran, A. V., Vallejo
Ebright, George E., San Francisco
Eloesser, Leo, San Francisco
Enloe, N. T., Chico
Evans, George H., Berkeley
Fairchild, Fred R., Woodland
Falk, Charles C., Eureka
Fisher, Carl, Los Angeles
Franklin, Walter Scott, Santa Barbara
French, J. Rollin, Los Angeles
Friedland, R. D., San Francisco
Gelston, Clain F., San Francisco
Graham, Harrington B., San Francisco
Gray, Horace, San Francisco
Gundrum, F. F., Sacramento
Haas, Sylvan L., San Francisco
Harris, Henry, Berkeley
Hill, Harold F., San Francisco

Hines, Don Carlos, Palo Alto
Hoffman, Lawrence H., San Francisco
Howson, Carl R., Los Angeles
Howard Burt F., Sacramento
Huggins, W. L., Los Angeles
Hurd, A. H., Hollywood
James, Martha Abigail, San Francisco
Johnson, Howard, San Francisco
Kellogg, Wilfred H., Berkeley
Kerr, William J., San Francisco
Kiger, William H., Los Angeles
King, Wenonah, Chico
Koefod, Hilmar O., Santa Barbara
Langstroth, Lovell, San Francisco
Legge, Robert T., Berkeley
Lobingier, Andrew S., Los Angeles
Loos, H. Clifford, Los Angeles
Mace, Lewis Sayre, San Francisco
Mack, Clifford W., Livermore
MacLeish, A. C., Los Angeles
McKee, A. B., Redwood City
McKibben, Paul S., Los Angeles
McNeile, Lyle G., Los Angeles
Meyers, Alfred E., San Francisco
Millspaugh, W. P., Los Angeles
Morrison, Wayland A., Los Angeles
Mortensen, W. S., Santa Monica
Myers, Glenn, Compton
Myers, Thomas C., Los Angeles
Nevius, John W., Los Angeles
Newell, R. R., San Francisco
Nuzum, Franklin R., Santa Barbara
Olds, W. H., Los Angeles
Park, D. B., Vallejo
Peers, Robert A., Colfax
Pierson, Philip H., San Francisco
Podstata, V. H., San Francisco
Porter, Langley, San Francisco
Pottenger, F. M., Los Angeles
Ramsay, Robert Ewart, Pasadena
Read, J. Marion, San Francisco
Reed, Edward N., Santa Monica

Reed, J. Ross, Pasadena
Reid, Eva Charlotte, San Francisco
Roberts, William Humes, Pasadena
Roble, W. W., Riverside
Rogers, L. B., Los Angeles
Rowe, Jr., Melvin John, Los Angeles
Ruggles, Howard E., San Francisco
Rude, Anna E., Los Angeles
Scholtz, Julius Robin, Los Angeles
Scholtz, Moses, Los Angeles
Schottstaedt, W. E. R., Fresno
Scott, Alfred J., Los Angeles
Seid, Martin J., San Francisco
Shepard, W. T., Palo Alto
Sherman, Julius, San Francisco
Shutes, Milton H., Oakland
Smith, A. M., Oakland
Smith, R. T., Pomona
Solland, Albert, Los Angeles
Spiers, H. W., Los Angeles
Stephens, Philip, Los Angeles
Stevens, William E., San Francisco
Stork, Victor E., Los Angeles
Sweet, Earl, Los Angeles
Taylor, Fletcher B., Oakland
Teass, C. J., San Luis Obispo
Templeton, H. J., Oakland
Terry, Wallace L., San Francisco
Tholen, E. F., Los Angeles
Thomas, Roy E., Los Angeles
Thorner, Moses, Santa Barbara
Trowbridge, D. H., Fresno
Van Dalsem, William S., San Jose
Van Nuys, R. G., Berkeley
Varden, A. E., San Bernardino
Voorsanger, W. C., San Francisco
Walker, G. W., Fresno
Wells, George S., Santa Barbara
Wiel, Harry I., San Francisco
Witherbee, O. O., Los Angeles
Wood, W. A., Oakland

How can self nominated specialists and ill qualified surgeons be controlled?

Now that the age of philanthropy is passing, how are hospitals to be supported?

Is insurance—3 cents a day—or direct use of tax funds the answer?

Should the United States have a ministry of health and set up a Federal Department of Health in the President's Cabinet?

Which, if any, of the following is the answer to present problems: the status quo? compulsory insurance? various forms of voluntary insurance? thoroughgoing state medicine? evolutionary increase in governmental authority and functioning, integrated with private practice?

* * *

The American Foundation's Approach to the Subject.—While it is not possible, here, to dilate upon this welcome contribution to the literature on the medical-economic and welfare topics discussed by the 2,200 physicians who give expression to their individual views on different phases of the problems, it may be permissible to state that the two volumes are free from open or furtive support of preconceived solutions of the problems considered; and that the "American Foundation Studies in Government,"—which concerned itself in the years 1924-1935 with studies in the field of international law and international relations,—have approached this first study in the field of domestic relations in the broadest spirit. Witness the following from the foreword by Judge Curtis Bok, chairman of the Foundation's Governing Committee:

In sending our inquiry to doctors in the first instance there was no assumption that doctors alone could solve the problem. Social scientists, economists, government administrators have certainly a contribution to make. But it seemed to us that the group best able to define the problem in the first instance are the qualified medical men of the country. They should have a better idea of what constitutes adequate medical care than any economist or any government administrator. The very nature of their work, moreover, puts them in touch with conditions that are social and economic as well as medical and scientific. . . .

To the above may be added an excerpt or two from the Introduction by Truman G. Schnabel, associate professor of medicine in the University of Pennsylvania:

The inquiry sent to these contributors was in effect as follows:

Has your experience led you to believe that a radical reorganization of medical care in this country is indicated? If so, in what direction? If you do not believe that radical reorganization is indicated, what, if any, changes or revisions in the present system would you like to see made? What evolutionary possibilities would you stress?

* * *

Doctor Schnabel adds that the objective of the Foundation's inquiry

was not to poll the medical profession upon anything whatever, but rather to assemble ideas. . . .

The intent and purpose of this report is to illumine and not to prove.

* * *

The American Foundation Studies in Government.—Concerning this organization, and its governing committee of thirteen, it may be observed that the name of Dr. Robert A. Millikan, Director, Norman Bridge Laboratory of Physics, California Institute of Technology, adds lustre to

the roll; while in addition to the 2,200 contributors, the Foundation appointed a Medical Advisory Committee of 134 physicians, on which California is represented by

Philip King Brown, San Francisco; Thomas O. Burger, San Diego; William F. Cheney, San Francisco; Arthur L. Fisher, San Francisco; William J. Kerr, San Francisco; Eugene S. Kilgore, San Francisco; Langley Porter, San Francisco, and F. M. Pottenger, Los Angeles.

Speaking of the Medical Advisory Committee, it is stated:

The American Foundation would like to make it explicit that the members of the Medical Advisory Committee who are hereby joined with us in presenting this report, of course, assume no responsibility either individually or collectively, for any of the ideas quoted or presented. The Medical Advisory Committee endorses this report as a fair summary of the views of their colleagues that replied to the inquiry; the committee endorses the integrity of the work, agrees with The American Foundation in the usefulness of making it available and commends it to the study and consideration of medical men and of the public.

* * *

How Subject Matter Is Divided.—For those who would know still more about the two volumes and how they cover the topic, "American Medicine," the following may suffice:

The report falls roughly into two divisions, as follows:

The first seven sections (890 pages) describe present trends in medical practice and in medical education. They analyze without reserve what is wrong and what is right with American medicine today.

The last four sections (440 pages) discuss various proposals—social and economic as well as medical—for "distributing" medical care and lowering its cost, and for organizing medical care and public health services.

In other words, in the first (and the larger) part of the report the doctors discuss chiefly medicine itself. In the latter part they venture into the field of social and economic theory. The much greater space and emphasis given to the discussion of medicine itself is not without significance. Medical scientists do not see any possibility of separating the social and economic aspects of medical care from the quality of medical care itself, as a dominant and controlling factor in all planning.

* * *

The Place of These Studies in the Literature.—It is our belief that these two volumes of American Foundation Studies on "American Medicine" are, thus far, the most valuable contributions on the subjects discussed, and that they will be studied and referred to when other reports of much greater length, but containing the outpourings of theorizing laymen will have been almost forgotten, except for some of their statistical information.

Fact-finding studies and surveys have been much the vogue in recent years; so much so, that most folks are apt to view with suspicion many such efforts. Here in California, the sad experience of spending some \$35,000 of the California Medical Association's funds, under instructions from the House of Delegates, is still too vividly near not to make us share with others the mistrust concerning the value of some of these so-called surveys. For our part, we believe that, had the two volumes on "American Medicine" been off the press at the time the California Medical Association embarked on its survey adventure, some three years ago, and had the House of Delegates ordered the purchase, and given to each member, for his own library, the two

volumes on "American Medicine," then our Association would have had, for less than half the money it expended, twice or thrice of what we shall ultimately receive in either value or satisfaction from the California Medical-Economic Survey.

The editor believes that members who secure the two volumes on American Medicine (at the moderate price for both of only \$3.50), will not regret their purchase.

ON PROPOSED LAWS BEFORE THE CALIFORNIA LEGISLATURE

Present Status of Certain Bills.—Late numbers of the OFFICIAL JOURNAL have given brief comments on various public health measures that are now before the two houses of the California Legislature awaiting consideration and action. In this issue, the status of these bills, to date of April 16, as given in the official publications of the Legislature may be learned by scanning the excerpts found on page 347.

Below appear some memoranda received from the California Medical Association's Committee on Public Policy and Legislation, and these give additional information of interest. The attention of readers is called to the proposed law that would bring into existence in California an additional cultist examining board, this having already been passed out to the Assembly floor, for consideration and vote by that body. It is to be hoped that members of the California Medical Association appreciate the significance of that situation. Comment on the naturopathic measure and other bills is made below:

County Hospitals.—Not one of the bills designed to open up county hospitals to pay-patients has thus far passed the Legislature. Assembly Bill 51 was tabled in committee. After a lengthy hearing, Senate Constitutional Amendment No. 5 was finally sent to the floor of the Senate for a vote, but the Committee recommended that it "do not pass." Assembly Bill 1196 failed to receive a favorable vote in committee.

Chiropractic and Naturopathic.—Assembly Bill 1472, to set up a Naturopathic Board with broad powers, came out of committee with a favorable recommendation by a margin of one vote, and is now before the Assembly for action. A deluge of "mail lobbying" by its sponsors has been let loose in favor of this bill.

Two Chiropractic proposals to extend the scope of the Chiropractic Act are still in committee.

Code Bills.—The bills prepared by the California Code Commission to codify the existing laws relating to medical practice, dental practice, and nursing, etc., are on the floor of the Senate, awaiting passage of the budget bill before they can be acted upon.

Board of Health—Dentistry.—Assembly Bill 1262 increasing the membership of the State Board of Health from seven to eight, and requiring that one member be a dentist, has passed the Legislature and has been signed by the Governor.

Osteopathic Bills.—Assembly Bill 1880 (osteopaths in schools) passed the Assembly, but failed to secure favorable vote in the Senate committee. An identical measure—Assembly Bill 684—has now been started through the Assembly by the osteopaths.

Health and Hospital Insurance.—Assembly Bill 1132, sponsored by the Association of California Hospitals to provide hospitalization insurance, has passed the Assembly and is now before the Senate committee. No action has been taken in committee upon Senate Bill 121 (Williams) and Senate Bill 605 (McGovern). Assembly Bill 1283

(Welsh) and Assembly Bill 1491 (Boyle, Cronin, and McMurray) are still in the hands of a subcommittee of the Assembly Committee on Insurance.

Venereal Disease Bills.—Assembly Bill 1089 and Assembly Bill 2790 have been reported to the floor of the Assembly with recommendation, "do pass as amended." Assembly Bill 2790† is the measure having the approval of the State Board of Health.

Compensation Act Amendments.—None of the bills proposing to open up the Compensation Act to free choice of healer (not confined to M.D.'s) has been acted upon by the Committee.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 331.

EDITORIAL COMMENT†

SYPHILIS AT THE CROSSROADS

The golden opportunity for the control of syphilis is at hand. The public conscience has been aroused. If medicine is ready to act, it can completely command the situation. Now is the time to pass the legislation that we have long desired. Teeth can be put into existing laws or the requisite new legislation can be passed. If medicine will accept the challenge of the public to show them the way, victory over venereal diseases is assured. The effect of the recent publicity given by the lay press to both syphilis and gonorrhea has aroused more public interest than any other medical subject for some time. It has stimulated frank discussion of venereal diseases in service clubs, women's organizations, and friends at the fireside. If the physician is listening, he will find that the majority of individuals are vitally interested in the problem. The family itself with growing children is vitally concerned; for certainly, no matter how careful the upbringing of children, a time may come when the tide of emotion may lead the growing youth into a venereal exposure. Alcohol adds unmeasurably to the danger. The example set by more experienced companions is rarely resisted by the young man early in college when they travel together to see the night life of the city. We cannot say that our own sons will not be so foolish, for we do not know all the secrets of their minds. To the average youth, sex is an exciting mystery, and no matter how thorough his moral training, a natural instinct will often set aside moral judgment.

The challenge is, therefore, thrown to the physicians. We must teach the danger that lies in promiscuous exposure, as well as an understanding of the disease itself, and proper protective measures. We must also be able to give hope to those who are already infected, and who consider their

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

‡ See also letter on page 345.

disease incurable. We must substitute facts for superstition. We must also teach that an infection of syphilis is often an unfortunate accident, and not a shame to be hidden from the rest of the family. The physician is likewise put on the defensive by the public itself, which is learning what is proper diagnosis and proper treatment. They will be coming to the doctor in a position to criticize, if incompetent methods are used. The man of medicine must, therefore, examine himself as to shortcomings in knowledge of the disease, and be sure that the handling of each case is thorough and efficient.

The physician should also examine his conscience in regard to the cost to the patient. It has often been the practice in the past to place a special charge on venereal cases. This should be considered pernicious and, therefore, be discontinued. Only a fair charge, in which the cost of the medicine is considered, should be made for the physician's services. The public health departments must also develop a better liaison between themselves, the clinics of teaching institutions, and the doctors. They must be willing to assist the physician in the control of his cases. They must have police powers both to control the infected individual and to see that he receives the necessary treatment for cure. The work should not be taken out of the hands of private physicians except in the case of indigents. If possible, the boards of health should be able to supply the drugs so that the physician can treat his cases at a cost less prohibitive to the great mass of common people.

Men and women of the Profession of Medicine, this is the opportunity of our greatest service to humanity in our present century. Let us not be derelict in accepting the challenge.

407 Medico-Dental Building.

MERLIN T.-R. MAYNARD,
San Jose.

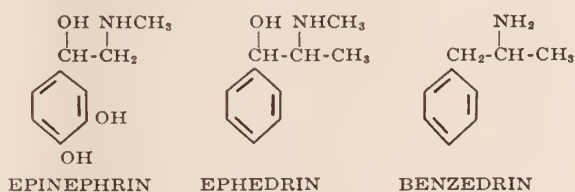
BENZEDRIN SULPHATE

There has been a tremendous amount of research recently in the field of pharmacology concerned with drugs having soporific, depressant or analgesic effects. It far outshadows, in volume at least, that concerned with drugs of a contrary action. The search for oblivion to pain, in other words, still occupies its traditional place in medicine, as it should, but lags with characteristic human inconsistency far behind the search for stimulation. Yet the latter, in the long run, will probably prove to be more important and fundamental in explaining the physiology of consciousness.

Among the more interesting groups of substances falling in the category of stimulants are those which bear a chemical resemblance to epinephrin. Ever since the chemical formula of this naturally occurring drug was discovered, attempts have been made to find chemically related substances that have all its desirable pharmacologic effects, but that would be active on oral administration, which epinephrin is not. In the search for such substances, the first of any importance to be discovered was ephedrin, also a naturally occurring

compound but, unlike epinephrin, from the vegetable rather than from the animal kingdom. Ephedrin, as compared with epinephrin, was found to have essentially the same therapeutic, if not pharmacologic, action, except that it was active by mouth and had a more prolonged, although weaker, vasopressor and broncho-dilator effect. In addition, certain side effects were noted which were not characteristic of epinephrin, particularly that of producing insomnia. With this property in mind Janota¹ used ephedrin for treatment of narcolepsy with encouraging results.

Meanwhile Alles,² studying synthetic compounds related to epinephrin, noted that they varied in their central stimulant actions; and of these compounds one has been introduced into medicine under the name benzedrin, in the form of its sulfate. It has long been known that pharmacologic action is often related to chemical constitution, and this has been further confirmed in the case of the related substances epinephrin, ephedrin and benzedrin.



Just as ephedrin differs in its action, in some respects, from epinephrin, so does benzedrin differ from both epinephrin and ephedrin. All belong to a group of chemically related, vasopressor compounds. Their vasopressor (peripheral or sympathomimetic) activity differs, however, in intensity and duration. Epinephrin acts with the greatest intensity and for the shortest time. Ephedrin is intermediate in both these qualities, and benzedrin is the least effective (1/100 to 1/200) that of epinephrin, but has a more prolonged effect. Like ephedrin, benzedrin is also effective on oral administration. Also like ephedrin, benzedrin has a marked central stimulating effect. Prinzmetal and Bloomberg³ have shown that it is more intensely and more certainly effective than ephedrin, as measured by its efficacy in the treatment of narcolepsy, being successful even when ephedrin fails.

It is this central effect that led Nathanson⁴ to investigate the action of benzedrin sulphate both in patients complaining of fatigue and exhaustion and in normal individuals. The results of this investigation have been most striking and distinctly unique in the field of therapeutics. In summary, Nathanson⁴ has found that the drug ameliorates fatigue and drowsiness, and produces a feeling of exhilaration, accompanied by an increase in mental

¹ Janota, O.: Symptomatische Behandlung der pathologischen Schlafsucht besonders der Narkolepsie, *Med. Klin.* 27: 278 (Feb. 20), 1931.

² Alles, G. A.: Comparative Physiological Actions of dl-B-Phenylisopropylamines, *J. Pharmacol. and Exper. Therap.* 27: 339 (March), 1933.

³ Prinzmetal, M., and Bloomberg, W.: The Use of Benzedrin for the Treatment of Narcolepsy, *J. A. M. A.*, 105: 2051 (Dec. 21), 1935.

⁴ Nathanson, M. H.: The Central Action of Beta-amino-propylbenzen (Benzedrin), *J. A. M. A.*, 108: 528 (Feb. 13), 1937.

activity and efficiency. This is often associated with a tendency to loquaciousness and unusual friendliness. Loss of weight, from prolonged use, is ascribed not to an increase in metabolic rate, but to an increased activity, lessened sleep and diminution of appetite. This latter may be due to dryness of the mouth, an atropin-like effect often noted. Nasal congestion from acute or chronic affections of the upper respiratory tract is often markedly relieved. Unpleasant effects noted, usually of mild degree, were sweating, tremor of the hands, palpitation, headache, nausea, dysuria and diminution of libido.

The optimum dosage varies with individuals. Generally, 10 milligrams before breakfast and 10 milligrams before lunch results in onset of effect within thirty minutes to one hour after taking the first dose, and persists for seven to twelve hours after the second dose.

Unlike epinephrin and ephedrin, prolonged use does not seem to diminish the effectiveness of the drug nor produce cardiac irregularities. Nathanson,⁴ however, warns that the increased activity, if carried beyond the capacity of a handicapped individual, carries with it obvious dangers. It is for this reason that its administration is to be undertaken only with the guidance of a physician.

In conclusion, it may be said that benzedrin is a drug which increases in great degree the awareness of an individual, a relatively unique pharmacologic phenomenon that opens new fields in the study of the physiology of consciousness.

672 South Westlake Avenue.

HYMAN MILLER,
Los Angeles.

Dentistry of 1864.—J. R. Dillingham of 12 Winter Street, Boston, sends us the following rules for the preservation of the teeth:

First: Let care be given to the teeth of children. Deciduous teeth (first set) may be extracted too soon, or left too long. If the fangs of the first teeth are absorbed, drop out, and give place to the second, all will be well. But if they appear on either side of the arch, lose no time in applying to a good dentist.

Second: When a concretion of tartar collects upon the teeth of a person of any age or sex, lose no time in applying to a dentist for its removal. Many lament the loss of a whole set of teeth from this concretion alone.

Third: When a tooth becomes sensitive from taking cold or warm drinks, or a cavity appears ever so small, lose no time in applying to a judicious dentist, as many teeth are totally lost by not being timely filled with metal. But when filled with proper materials, and by a skilful dentist, it will preserve them, not for a few months only, but for a whole life. The bad effects produced by bad breath, occasioned by one or more diseased teeth, are not of small consideration. If the effects produced by such breath be so extremely unpleasant to the olfactory nerves of other individuals, what must be the effect upon the delicate tissues of our own lungs?

Fourth: All teeth too much decayed to be saved by plugging, and all roots, should be extracted, lest they injure the health of the general system.

Fifth: Lost teeth should be artificially restored, since they are rendered at once permanent, beautiful, and answer all reasonable expectations of the patient as regards articulation, mastication, and natural appearance.—*Found by R. S., New York, in Godey's Lady's Book and Magazine, July, 1864, p. 93.*

ORIGINAL ARTICLES

HUMAN BETTERMENT*

By EDWARD M. PALLETTE, M.D.
Los Angeles

FOREWORD.—Everyone, no doubt, is influenced more or less by his immediate surroundings. The following paper was written by me on a very recent six weeks' cruise along the shores and among the islands of the Gulf of California; or, as the Mexicans call it, the Vermilion Sea, or the Sea of Cortez.

Our ship† was a beautiful 200-foot Diesel-powered steel cruiser, ideally constructed for the purpose of making expeditions of exploration and doing scientific collecting. The accommodations were most comfortable, the food was excellent, the scenery inspiring, and the collecting very interesting. The ship possessed an excellent library of travel and natural science. Our company was a group of biologists and other scientists, all industrious and enthusiastic in their work. Life seemed full and well worth living.

I was, of course, influenced by the immediate environment, which was distinctly biological; but after returning home and rereading the paper, it was decided to leave it as written, although with the consciousness that it probably presents to a group of physicians some elementary biology with which they are already familiar.

I would make a plea for a wiser distribution of charity. I would call the attention of educators, preachers, social workers, lawmakers, and physicians to certain well-recognized findings of the science of biology.

BEGINNINGS OF LIVING THINGS

To even the casual reader of history it is obvious that the story of the long life of man upon earth has been one of a succession of civilizations, each more or less distinct, in time and place, from the others. Archaeologists tell us that there are evidences of at least seven of these civilizations in very remote and prehistoric times. There have been at least an equal number since man began leaving written evidence of his doings.

It is estimated that life first appeared upon the earth about five hundred million years ago, beginning with microscopic, single-celled, marine forms, these becoming more complex and more highly developed through the ages. About five million years ago our remote ancestors gradually acquired those characteristics which entitled them to be called human. Then followed long ages of savagery to be succeeded by other long ages of barbarism and semi-barbarism, men living the lives of wild beasts in the jungle.

THE FIRST CIVILIZATIONS

Back along this long line of darkness there was an occasional gleam of light. Some group of men

* Address of the retiring president. Read before the first general meeting of the California Medical Association at the sixty-sixth annual session, Del Monte, May 3 to 5, 1937.

† *Velerio III*, Captain G. Allan Hancock.

somewhere had developed those superior traits of mind and body which had enabled them to emerge from barbarism into those ways of living which we call civilized. This civilization would flourish for a time and then decline and disappear. After many centuries, another bright spot would appear in the darkness, usually in a different part of the world and among a different people. Then this light would go out, to be followed by long ages of semi-barbarism. Many theories have been advanced as to the causes of the downfall of these civilizations, especially during historic times. It is said that the Greco-Roman culture, the greatest of all before our own, declined; because of the invasion of the barbarians; then came the adoption of Christianity, with its policy of nonresistance and turn the other cheek; corruption in living and government; the breeding of the incompetent among themselves; and malaria.

EPIDEMICS A FACTOR IN DECLINE OF CIVILIZATIONS

In writing the story of the decline of civilizations, too little attention would seem to have been given to the influence of epidemic disease. Some day a historian will write with more knowledge of epidemiology, and a different story may result.

Egypt is a good example. Shut in by desert and sea, the ancient Egyptians, through untold ages, developed a high grade of culture. Then they began going out and conquering other people and bringing the conquered tribes home with them as slaves. With these they brought diseases, against which they had no resistance, and they themselves were weakened and went into a decline. The mummy of Seti II, one of the greatest of the Pharaohs, in his glass case in the museum at Cairo, plainly shows the fresh lesions of smallpox, of which he died. A very large percentage of the poor, incompetent inhabitants of Egypt at the present time suffer from schistosomiasis. The cysts of the organism of this disease are found in the mummies of Tutankhamen's time.

Malaria contributed much toward the fall of ancient Greece and Rome.

In Yucatan and Guatemala, the twelfth century, A. D., showed a highly developed culture among the Mayans, who left a record in stone of the number who died each year from "black vomit," or yellow fever, until none was left to longer make the record.

In Cambodia, in French Indo-China, the wonderful ruins of Angkor were discovered seventy years ago, where they had been lost and forgotten for five centuries. Little is known of the people who built there, and nothing of what became of them. It is significant, however, that the last buildings erected by these people, a group a few miles away in the jungle, was a hospital. They seem to have been destroyed by an epidemic which they did not know how to fight.

COMMUNICABLE DISEASES AND PRESENT-DAY CIVILIZATION

It is safe to assume that our own civilization will not be destroyed by communicable disease. Our knowledge of epidemic diseases and their con-

trol and prevention is too complete. Diseases which have, in centuries gone by, ravaged the civilized world, and all but depopulated whole countries, such as bubonic plague, yellow fever, cholera, smallpox, and malaria, are now almost exterminated, and others, such as tuberculosis and diphtheria, are well under control.

THE FATE OF OUR OWN CIVILIZATION?

What then of our own boasted civilization? Will it continue indefinitely, or will it go the way of all others and disappear? It is not pleasant to think that our children's children may go into another age of darkness or live subservient to a people of another race and language, perhaps of another color.

ORGANIC EVOLUTION

The doctrine of organic evolution is a very old one. The Greek, Empedocles, of the fifth century, B. C., has been called the father of the evolution idea. This was developed more fully by Aristotle a hundred years later. Then the idea declined, and during the Middle Ages only an occasional thinker referred to it. Following the Renaissance several natural philosophers revived interest in the subject. Among these were Bacon, Descartes, Leibnitz, and Kant. Then came the great naturalists of the eighteenth century, Linnaeus, Buffon, Erasmus Darwin, Lamarck, and Couvier—all evolutionists.

Charles Darwin, whose name is so closely associated with the evolution idea, advanced, in his *Origin of Species*, the Theory of Natural Selection, that evolution has taken place because of the struggle for existence among all organisms, and the resultant survival of the fittest. This is Darwinism. A great controversy followed the publication of Darwin's books, but since his time practically all scientists and most other educated men have been supporters of the doctrine of evolution.

Charles Darwin and Abraham Lincoln were born the same day, February 12, 1809, and have been referred to as the two great liberators—one of men's minds, the other of their bodies.

Most scientists have accepted the theory of natural selection. The differences of opinion and many efforts of research have been along the lines of attempting to discover the methods by which the fit are produced. The paths by which living things acquire those qualities which enable them to survive are several. It is generally agreed that whatever forces are operative in producing variations in plants and animals, the principle of natural selection is a constant and dominant factor in organic evolution.

SURVIVAL OF THE FITTEST: APPLICATION OF THE DOCTRINE TO PRESENT-DAY TRENDS

Ever since life first appeared upon the earth the ancestors of mankind have struggled to exist and only the fittest have survived. You and I may not be very smart, but we can be quite sure that our ancestors of a few hundred years ago were very smart men and women, because in all the ages past only the smartest survived to that time of life when they could bear offspring. This is not so true in recent times.

Ancient Rome divided her people into six classes. The lowest of these were supported by the state and were excused from all civic duties, including the payment of taxes, voting, and military service. They were called the proletarians, and were expected and urged to have many children in order that the population might be maintained. No wonder Rome fell!

But are we not doing the same thing and worse? We not only support our ever-increasing proletariat, giving them, without charge, housing, food, clothing and the best of medical and hospital care, and excuse them from paying taxes and encourage them to have large families—which they would do without any encouragement!—but we permit them to choose, often from among themselves, the men who make our laws, and the men who execute our laws, and the men who sit in judgment upon our laws.

WORLD WAR INTELLIGENCE TESTS

During the World War an intelligence test was made upon nearly two million United States soldiers. The results were not very encouraging. Sixty per cent of these picked men, including the officers, gave a rating of fourteen years or under. If 60 per cent of our men in the World War had an intelligence of only fourteen years or under, it is safe to say that at least an equal percentage of all American men are in that class. And how about the women? There are no corresponding figures for women, but it is fair to assume that we are not overchivalrous if we give them the same rating. We hear somewhat of the adolescent female mind, but it is probable that for all the adolescent female minds there are an equal number of adolescent male minds running loose.

At least 60 per cent, then, of our adult population is adolescent. Most of what is published in our newspapers is for adolescent consumption. The majority of the books and magazines now being printed are written for adolescents. A large part of the broadcasting over the radio is for the doubtful benefit and entertainment of adolescents and morons. The "movies" are supported by the same group, for these people need a great deal of entertainment. Jazz music is all definitely moronic—composers, producers, consumers. We would not exactly recommend that all jazz orchestra leaders be lined up and shot at sunrise, but the suggestion has been made, and it is perhaps quite worthy of consideration. And much of this ultra new art stuff is worse than moronic. To the average mind it is imbecilic if not positively psychopathic.

And morons all have large families of physically healthy little morons—always morons.

Only 50 per cent of the graduates of leading women's colleges in America marry, and each of these has only one-third as many children as does the noncollege woman. In other words, the graduate of the women's college bears only one-sixth as many children as does the average American woman. We have not the figures for the alumnae of coeducational institutions; they may not be so bad. Phi Beta Kappas have still fewer children than do the average college graduates.

STREAM OF HEREDITY

A fairly accurate mental test of adults could be based upon the number of children born—the fewer the children the higher the intelligence of the parents. Many statistics could be adduced showing that the normal and supernormal are bearing fewer children, while the subnormal and dependent are bearing more and more; and it is also true that, while the offspring of the normal and supernormal may not always be supernormal or even normal, the offspring of the subnormal are always subnormal. No heredity stream ever rises higher than its sources.

RELATION TO POLITICAL ORGANIZATION

If the legal age for voting, instead of being twenty-one calendar years as at present, were based upon an intelligence test and placed at, say, sixteen years, it would reduce the number of voters much more than one-half and might solve some of our problems. Many believe that an intelligent government, even if not altogether honest, is much safer than an unintelligent government even though this be thoroughly honest. It is too often both unintelligent and dishonest.

We are fast approaching a condition when we will be a nation of adolescents governed by adolescents, for adolescents. Or, if you will, a nation of subnormals, governed by subnormals, for subnormals.

But this is not the worst of it; for the world has much work for the 12 to 14-year-old man and woman to do. They play an important part in the social and economic set-up. It is the low-grade moron, the feeble-minded, the insane, the criminal, the drug and liquor addicts, the confirmed pauper, that should worry us.

I will not burden you with figures, but we all know that feeble-mindedness, insanity, crime, drug and liquor addiction, and pauperism are all rapidly on the increase.

Since time began, our ancestors had to fight to survive. They all had to struggle, and it was a case of the devil taking the hindmost. The devil took not only the hindmost, but he took all but the foremost. We are changing all this and making it possible for the devil to take the foremost.

PRESENT-DAY CIVILIZATION: SOME RECENT FACTORS

In comparatively recent years our civilization has come to differ from all others in two outstanding respects—the marvelous development of mechanical inventions, and the wonderful discoveries of science. A third element has entered the picture which is new to the world—an enormous development of emotional sympathy for the down-and-out, the weak, the sick, the insane, the incompetent, the poor, all those who in all previous times, even in previous civilizations, have been exterminated by a pitiless nature.

Professor E. G. Conklin writes:

"If society had deliberately set about the propagation of the unfit, it could hardly have devised more effective means than many of those which are now in vogue.

"For the first time in the history of life upon the earth, a single species now has the power of controlling to a large extent its own evolution, and it has begun by radically changing some of the conditions of progress which have prevailed hitherto. A large part of the human race is now engaged in the most stupendous and dangerous experimentation upon itself; without any adequate knowledge of the mechanism of evolution, it has begun to tinker with that mechanism, throwing certain parts out of gear, destroying others, and in general paying little or no attention to the results."

We would not for a moment recommend less of sympathy for the unfortunate and incompetent. They must be cared for by every means possible. We can, however, do much to prevent them from propagating, for they cannot propagate any other kind than their own kind.

HEREDITY AND ENVIRONMENT

The heredity and environment discussion is very old, but all modern biology teaches that heredity plays the preponderant part in shaping men's real natures and abilities. Environment gives men opportunity for achievement, but heredity determines which men will avail themselves of that opportunity and the extent to which they will achieve.

Our knowledge of the laws and mechanism of heredity has increased enormously since the beginning of the present century. Biologists believe that environment and training are very minor factors in human development.

Heredity may be defined as the tendency of offspring to resemble their parents. Until the time of Weismann, fifty years ago, it was generally believed that the offspring inherited from the entire bodies of the parents, and that characteristics acquired by the parents were transmitted to the offspring. Weismann taught, and this has since been generally accepted, that inheritance takes place from the germ plasm only, of which the parents are mere carriers, and that acquired characters are not transmitted.

The science of genetics seeks to determine the physical basis of heredity. Much progress has been made along this line. All are familiar with the laws of Mendel.

In the right to life, liberty, and the pursuit of happiness all men are equal. In all other respects all men are born unequal and they will always be unequal. Due to the all-powerful influence of heredity, they are unequal in their natures and in their capacities.

It is not only the biologists who tell us that heredity is far more influential than environment. The behaviorists among the psychologists insist that "ninety per cent of a man's behavior is due to his heredity."

It has been said, "It is man who makes his own environment, and not environment that makes the man."

EUTHENICS

Euthenics, the science of learning to live well, applies to education and environment. Eugenics,

"the science of being well born," has to do with heredity. Both are attempts at human betterment. The biologist teaches the importance of the germ plasm. The sociologist emphasizes the importance of educational endeavor and environment. Each of these must learn his lesson from the other. Without an educational and environmental opportunity, the best of heritages is handicapped.

EUGENICS

Doctor Davenport, working in the field of eugenics, urges that we "dry up the streams that feed the torrent of defective and degenerate protoplasm." Toward this end it is suggested that, in the United States, the following agencies be employed:

1. A more strict control of immigration.
2. Marriage laws requiring medical examination and other restrictions.
3. Education of the public in matters of eugenics.
4. A more extended sexual separation of defectives in public institutions.
5. Sexual sterilization of certain types of defectives.

AMERICA AS A MELTING POT

The idea of America as a melting pot and asylum for the down-trodden of all the world, conceived in the days of our ignorance of matters eugenic, arose from an exaggerated sympathy and an overconfidence in our own ability to extend aid. America owes much to her early immigrants, but in later years many undesirable and unassimilable stocks have come in. Both statistical studies and animal experimentation show that the offspring of stocks which are widely separated are weaker than either parent stock. This is especially true after the second generation.

A few years ago I made a Mediterranean tour, visiting all the countries bordering on that historic inland sea—southern Spain, southern France, southern Italy, Greece, Turkey, Syria, Palestine, Egypt, Tunis, Algiers—and came home with the feeling that I would like to build a wall around America a mile high and shoot anyone who tried to look over it.

IMMIGRATION

Goddart, in discussing mental tests for immigrants into America, states that "the average steerage passenger is of low-grade intelligence, perhaps even feeble-minded." An examination made by him of those arriving, by Binet tests, showed that only one in seventy-four scored as high as twelve years, "which is regarded as the line between feeble-mindedness and normal." These immigrants were from the south of Europe.

It is stated that in one year more than seven thousand were refused admission to the country at Ellis Island alone. These included idiots, feeble-minded, insane, paupers, applicants with communicable diseases, prostitutes, and criminals.

It has been suggested that our laws of immigration be made more strict, and that trained inspectors be placed abroad in those countries from which immigrants are coming, and that they look into the ancestry as well as make personal examination of applicants.

MARRIAGE AND STERILIZATION

All applicants for license to marry should be required to pass a strict medical examination. Those found to be eugenically unfit to have children should be permitted to marry only after sterilization.

STUDY OF EUGENICS IS NEEDED

The public should be educated in matters of eugenics. Biology should be a required study in all high schools, with emphasis upon its eugenic implications. I would here make two suggestions to our educators: First, that instead of compelling all boys and girls to go to school till they are eighteen years of age, I would not permit them to go after they are fourteen unless they do a satisfactory grade of work. Our high schools and colleges are cluttered up with a lot of boys and girls who would be better off if they were at home and at work. Second, that the schools give less time and effort to the subnormal and "underprivileged," and pay more attention to the normal and supernormal. The prime object of our educational system should be training for leadership. The world needs properly trained leaders, and the leaders come from the supernormals.

STERILIZATION AS A EUGENIC REMEDY

Sterilization as a eugenic remedy is perhaps somewhat radical at this time, but after a sufficient education of the public it will no doubt become far more general and effective. More than half of the American states have passed laws compelling or permitting the sterilization of those with the most evident hereditary defects. Under certain limited conditions California, the third state to enact such a law, has, to date, sterilized about ten thousand patients under this law—more than any other state.

The German sterilization law is more comprehensive and applies to such conditions as feeble-mindedness, schizophrenia, Huntington's chorea, hereditary blindness, hereditary deafness, hereditary physical deformity, and severe alcoholism. It is mandatory, and special courts are available for passing judgment in such cases. If German plans along this line are carried out, a superior race will result.

BIRTH CONTROL

The best we can say for the birth-control campaign, as now conducted, is that, eugenically, it is a gesture perhaps in the right direction. It may aid in arousing public interest in eugenics. On the whole, it is probably detrimental to race betterment. The intelligent class of people, who should have more children, avail themselves of the information furnished by the birth-control propagandist, while the unintelligent, the class who should be reached, are too ignorant, indifferent and careless. However, properly conducted birth-control clinics among the very poor should be encouraged.

Among all organisms, both plant and animal, it is true that any characteristic of structure, function or habit which assists in the survival of the species to which that organism belongs persists, while any characteristic which does not so assist either

disappears, or the species to which it belongs disappears.

APPLICATION OF NATURAL SELECTION TO HUMAN ACTIVITIES

As applied to human activities, the doctrine of natural selection means that all those characteristics, whether of structure, function, or activity, which tend to race advancement and ultimate race survival, are good; while all those characteristics which do not so tend are bad. This may be said to be the biologic basis of ethics. All things are right which contribute to race betterment and race survival, and all things are wrong which do not so contribute. This is the yardstick by which every rule of human conduct should be measured. All permanent elements of religion must rest upon this basis. All systems of ethics must conform to it. All living nature, both plant and animal, is filled with instances where individuals sacrifice self, or are sacrificed, for the good of their species. This is the rule we must constantly have in mind in considering the problem of the care of the great mass of incompetents among us: What is the best for the race of the future?

IN CONCLUSION

Wars will continue and they may disrupt the world. We may be overwhelmed by the load of the defective and incompetent among us, and our civilization may go the way of all its predecessors. But "they that shall be of us shall build up the old waste places." Those young men of good heredity who marry the right young women of good heredity may rest assured that their children and their children's children, if they marry wisely, will rise above the wreck and ruin, and build for themselves and their posterity great and happy and heroic lives.

"When young men have vision the dreams of old men come true."

1930 Wilshire Boulevard.

VENEREAL DISEASE CONTROL PROGRAM:
DEPARTMENT OF PUBLIC HEALTH,
STATE OF CALIFORNIA*

By HOWARD MORROW, M.D.
San Francisco

FOREWORD.—The California State Board of Public Health established the first bureau of venereal diseases to be organized within any state health department in the United States. This bureau was established in 1917, and functioned actively for three years until Federal and State funds were withdrawn in 1920. Because of lack of funds, it was necessary to discontinue the bureau work; but it has of late been reestablished, through the use of Social Security funds, and is again actively engaged in the development of a program for venereal disease control in California. It will promote and coördinate activities in local, city and county health departments and endeavor to adjust the State program with that developed by the Fed-

* From the Office of the President, Board of Health of the State of California.

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eral Government. With the addition of State funds through pending legislation, these programs in local communities will be greatly extended.

OBJECTIVES OF THE BUREAU OF VENEREAL DISEASES OF THE CALIFORNIA STATE BOARD OF HEALTH

The general objectives of the Bureau are :

1. To provide adequate facilities for treatment of venereal diseases.
2. To assist clinics to the end of improving standards of diagnosis and treatment.
3. To distribute drugs, without cost to clinics, meeting required standards, and to private physicians whose patients are unable to pay for the same.
4. To promote epidemiologic investigations into both syphilis and gonorrhea in order that sources may be controlled, contacts investigated, and delinquents returned to treatment.
5. To promote the complete reporting of cases of venereal diseases.
6. To conduct an informative and educational program for the benefit of the general public.
7. To inform the medical profession of new methods in the treatment of venereal diseases as they develop.

ALL PERSONS HAVING VENEREAL DISEASE SHOULD BE TREATED

Of first importance is the provision of treatment for every case of venereal disease in California. All patients who are able to pay shall be cared for by private physicians, as is the custom in every case involving medical care. Facilities for the care of indigent patients are now available in free clinics located, for the most part, in the larger centers of population, and they will be extended to include migratory patients. In such clinics the following services should be available :

(a) The diagnosis and emergency treatment of any patient who applies.

(b) The diagnosis and treatment of any patient who is referred by a private physician, either for continued treatment or for consultative advice and opinion.

(c) The treatment of any patient who is unable to afford private medical care.

All such patients will be investigated and the economic status of each ascertained. All patients who are able to afford private medical care will be referred to private physicians. These requirements are, essentially, those now observed in most clinics throughout the State.

MEDICAL SERVICE SHOULD BE ADEQUATE

Efforts will be made to raise the standards of medical service within the clinics, so as to insure adequate diagnosis and treatment. Clinic record forms are being prepared for distribution in order to improve the standards of record keeping. Every effort will be made to assure continuous treatment of clinic patients. Transients are to be provided with identification cards that will admit them to any clinic coöperating with the State Department. It

is believed that, in so far as possible, physicians should be paid for their services in the clinics. Many clinics throughout the State are paying either part-time or full-time physicians for their services.

EXISTING VENEREAL DISEASE CLINICS

At present venereal disease clinics are being administered by the following general organizations :

(a) Full-time health departments with the health officers in charge, and either full-time or part-time physicians administering treatment.

(b) County hospitals entirely independent of health departments.

(c) County hospitals in which the hospital and public health departments are administered by a single department.

(d) Private charitable institutions.

(e) Medical-school clinics.

These general classes of clinics will continue as at present, but it is proposed to provide closer coöperation between the clinics and health departments in order to develop efficient epidemiologic work. The means by which this can be accomplished will vary from clinic to clinic ; but, in general, the services of local health departments will be available to investigate cases, contacts and sources of infection.

RURAL PROBLEMS

The treatment of indigent patients in rural communities will require special provisions. Funds for treatment of indigent patients in rural communities and, if necessary, for transportation to places where treatment can be obtained will be provided.

DISTRIBUTION OF DRUGS BY THE STATE

The free distribution of drugs, which has been carried on to a limited extent since 1917 by the State Department, will be extended. Present plans call for the distribution of drugs to charitable institutions, clinics, and to private physicians for the treatment of indigent cases. In so far as is possible, such distribution will be conducted through local health officers.

ISOLATION AND HOSPITALIZATION FACILITIES

Facilities for isolation and hospitalization of venereal disease cases are now quite inadequate. Many clinics at the present time are established in connection with hospitals. Such hospitals will be required to accept patients for isolation if help is to be extended to the clinics. Additional isolation facilities must be provided in many districts of the State. This will be done as local communities are educated to the necessity for such facilities and as funds can be raised for the purpose. As an integral part of this provision of isolation facilities, there is included the provision of facilities for pyrotherapy, which method of treatment is coming to play an ever-increasing rôle in the treatment of these diseases.

There are now available a number of diagnostic centers throughout the State in conjunction with medical-school clinics. Plans are going forward to enlarge and extend these services.

EFFORTS TO IMPROVE TREATMENT STANDARDS

The treatment of syphilis is subject to a limited degree of standardization. A special bulletin is being issued by the State Department of Health in which the modern treatment of syphilis is described. Copies of this bulletin are to be disseminated among clinics and physicians of the State. A second bulletin outlining modern trends of treatment of gonorrhea is being prepared. It is hoped that with these efforts, together with wide publicity, the general standard of treatment of venereal diseases throughout the State can be materially raised.

An effort will be made to eliminate the prenatal transmission of syphilis. Publicizing the necessity for blood Wassermanns in every pregnant woman is planned.

ADEQUATE EPIDEMIOLOGIC WORK IMPORTANT

Next to treatment, adequate epidemiologic work is probably most important. By a recent ruling of the State Board of Public Health, the morbidity report cards have been changed. Through publicity, education and appeals to coöperation, as well as legal measures where indicated, physicians will be encouraged to report all cases of venereal diseases. In addition to sending in morbidity report cards on each case, all clinics will be required to send monthly reports to the State Department. Laboratory reports will not be accepted as case reports, but will be used only for checking purposes.

Physicians are required by law to report venereal diseases. In addition, they are to report to health officers any cases lapsing from treatment while still in the infectious stage of the disease. The health officer shall then see that the patient is returned to treatment, enforcing quarantine and isolation in a hospital if necessary. The health officer is also responsible for keeping clinic patients under treatment until rendered non-infectious.

It is desired that every early case of venereal disease shall receive a complete epidemiologic investigation. This will include investigation into the source of infection and all possible contacts. Efforts will be made to bring these contacts in for examination and, if necessary, for treatment. In addition, efforts are to be extended to keep patients under treatment for the required length of time.

STATE BACTERIOLOGIC LABORATORY

The State bacteriologic laboratory will pursue essentially the same course that it has in the past by running tests for all State institutions and certain other private agencies. As in the past, tests will be run on specimens from private patients who are unable to pay for such services, provided these specimens originate in districts not taken care of by local health department laboratories. As in the past, the State bacteriologic laboratory will be available for checking and standardizing of tests run by any laboratory in the State. The plan is not to extend the State bacteriologic laboratory's activities, but to use them, in so far as is possible, to bring up the general standards of laboratory service throughout the State.

EXTENSIVE EDUCATIONAL PROGRAM PLANNED

An extensive informative educational program is being outlined. As indicated above, special bul-

letins are being prepared for physicians. In co-operation with the state and county medical societies, special courses in diagnosis and treatment of venereal diseases are being outlined for presentation to county medical society groups. A number of county medical societies are proceeding with plans of their own in this respect. It is hoped that special courses can be arranged in medical schools for physicians who are interested in obtaining additional information relative to these diseases. In an effort to obtain more definite information concerning the incidence of these infections, surveys will be run from time to time throughout various districts of the State. Questionnaires have already been sent out to several counties.

Literature is being prepared and accumulated for distribution to patients by physicians and clinics. Informative programs for the general public are being prepared. These will include newspaper publicity, lectures, pamphlets, posters, radio addresses, etc. The general public is to be informed particularly concerning the economic costs and benefits from control of these diseases.

In conclusion, it may be stated that the constituted public health authorities of California have in mind a venereal disease program that will aid, in fullest measure, the eradication of venereal disease, but along lines that will not make for confusion or low-standard results through officious meddling with the work of licensed physicians in private practice.

State Office Building, McAllister and Larkin streets.

THE EXTENSIVE SIDE-ACTIONS OF BARBITALS AND THEIR TREATMENT*

By P. J. HANZLIK, M.D.
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DISCUSSION by C. H. Thienes, M.D., Los Angeles;
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Los Angeles.

THE object of this paper is to draw attention to actions of barbitals which are oftentimes overlooked in the enthusiastic reception of some highly exploited use, such as the intravenous for analgesia or anesthesia. The actions referred to are the undesired side-actions, some of which are unavoidable in the ordinary uses of barbitals. They shed a light on the irregularities in actions and the physiologic disturbances met with in the use of these drugs.

Since 1929, I have been in the habit of demonstrating to medical students three graphic records which illustrate depression and paralysis of peripheral neuromuscular elements in the autonomic system caused by amytal. They are presented here in Figures 1, 2, and 3, which illustrate depression of the circulation, vagal ganglia, and intestines, respectively. The results illustrated in Figures 1 and 2 agree in all essential respects with recent reports of Koppányi and coworkers,¹ and are to be regarded as confirmatory. The same holds true

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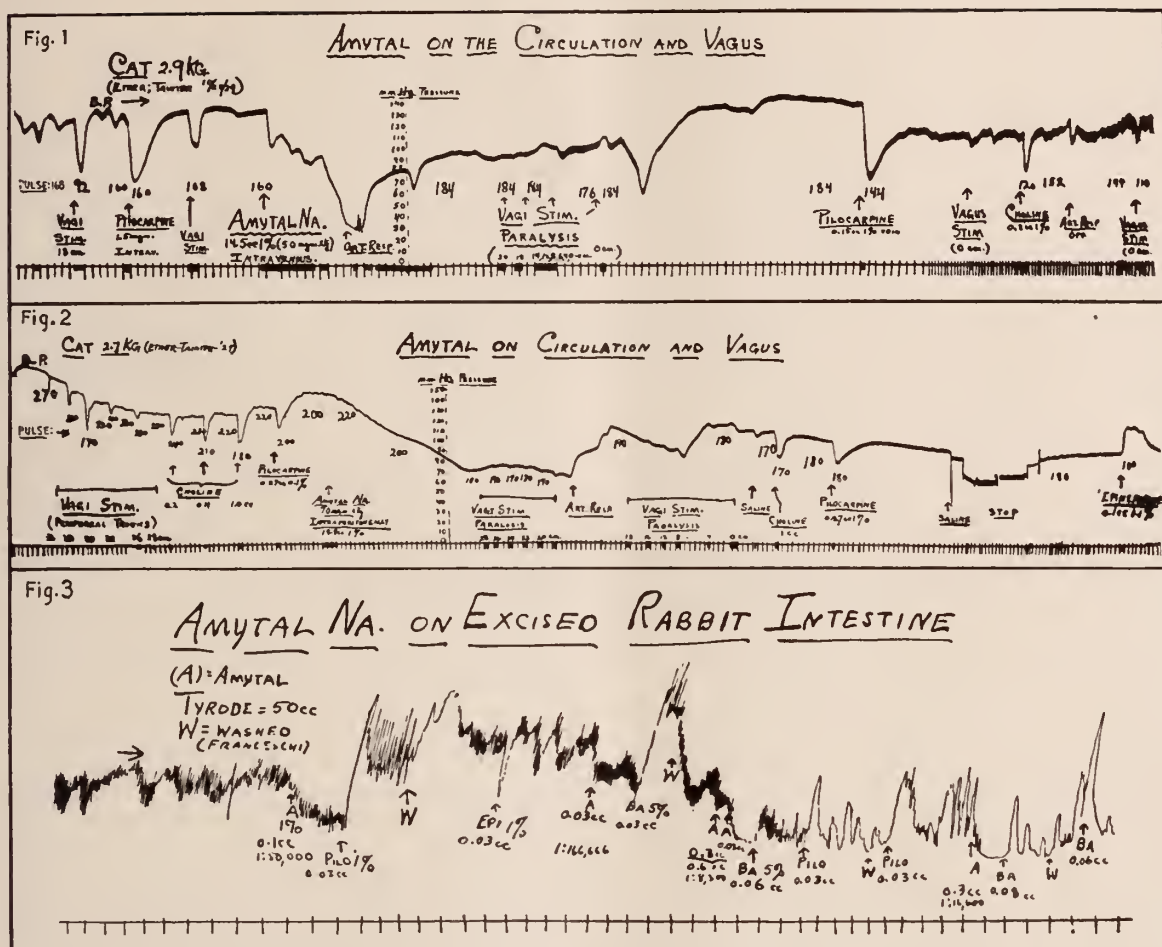


Fig. 1.—Amytal intravenously in a cat. Depressant effects on blood pressure, pulse rate and vagus ganglia are shown; pilocarpin and cholin, effective before and after amytal; collapse required artificial respiration.

Fig. 2.—Amytal intraperitoneally in a cat. Depressant effects on blood pressure, pulse rate and vagus ganglia are shown; cholin and pilocarpin effective before and after amytal, epinephrin after amytal; artificial respiration for the depression.

Fig. 3.—Amytal on excised intestine of a rabbit. Weakened reactions to pilocarpin, epinephrin and especially barium, as stimulants for autonomic nerves and muscles are shown.

for the results in Figure 3, which confirm the work of others. These confirmations clinch the evidence experimentally and dispose of some uncertainties about the nature of the side-actions.

CIRCULATORY AND VAGAL GANGLIONIC DEPRESSION

The legends on Figures 1 and 2 are self-explanatory as to the occurrence of events in two cats receiving injections of sodium amytal in so-called anesthetic dosage—one intravenously, the other intraperitoneally. Briefly recapitulated, the phenomena are as follows: depressor or collapse action (fall of blood pressure); paralysis of vagus control of the heart without loss of function in the peripheral receptive mechanism (ineffective vagus stimulation; fall of blood pressure and bradycardia from cholin and pilocarpin); absence of central and peripheral vasomotor paralysis (recovery of blood pressure, and pressor action of epinephrin, positive); cardiac depression suggested by bradycardia or tachycardia, with constant loss of vagus control; reflex cardiac slowing improbable (ineffective peripheral vagus stimulation). Presumably, direct cardiac depression is the cause of the circulatory collapse. A justifiable

conclusion is ganglionic paralysis or synaptic block in the cardiac vagi, an action of the amytal paralleled commonly by such poisons as nicotine and lobelin, and sometimes by cholin. This paralytic action has been further analyzed and conclusively demonstrated pharmacodynamically by Koppányi, Dille, and Linegar.¹ It does not require intravenous injection of a barbitol.

The ganglionic paralysis blocks the transmission of both efferent and afferent impulses in the cardiac vagi, and in case blockage extends to other branches of the vagi, and parasympathetic nerves in general, this action of barbitals interferes with visceral reflexes, some of which are protective, such as vomiting and coughing. On the other hand, the ganglionic paralysis, together with the central depression of a barbitol, would make an effective combination for controlling asthmatic attacks of reflex origin.

INTESTINAL DEPRESSION

All the functional elements in a strip of excised rabbit intestine are included in the depression, the muscles perhaps more than the nerves (Figure 3). Muscular depression is shown by a progressive decrease in tone and rhythmic activity, and in re-

action to barium. The autonomic nerves reacted satisfactorily to pilocarpin and epinephrin after poisoning with amytal in low (1:50,000) concentrations, as compared with unpoisoned intestines (not shown here). But after high concentrations (1:8000), the reactions to the same poisons rapidly declined. The concentrations of amytal used for demonstrating these depressant actions were higher than those attainable in the same tissues after oral administration of amytal. However, the moderate depressions of the low concentrations indicate effects of anesthetic doses of amytal given intravenously, and those of higher concentrations of repeated and toxic injections. They are confirmatory of depressant effects described by Gruber² for a number of barbitals in a considerable range of concentrations, and those of Quigley, Barlow, and Himmelsbach,³ using the intact gastro-intestinal tract.

For sake of completeness, the following list of side-actions is recorded: gastro-intestinal flaccidity and reduced peristalsis, decreased intestinal absorption of dextrose, decreased consumption of sugar by skeletal muscles, decreased urine secretion, alarming restlessness, delirium or stupor, paresis of the tongue, cyanosis and asphyxia, skin rashes, arsenic-like paralysis of capillaries, pulmonary congestion and edema, mucoid degeneration of the brain;⁴ depression of the spinal cord and reflexes, emphasized recently again by Porter and Allamon;⁵ blood-destruction and anemia with intravenous anesthetic doses of evipal, a much-exploited barbitat at the present time;⁶ increased blood sedimentation and reduced cell volume with slow return to normal after a number of barbitals and evipal;⁷ very marked reduction of urine output in nephritis;⁸ cardiac irregularities after barbitat;⁹ persistent depression or paralysis of vasomotor reflexes (aorta and carotid sinus) and centers with marked respiratory depression after evipal;¹⁰ precipitation of barbitals in the blood stream with intravenous activation of reflexes from the trunk, aorta, and carotid sinus, resulting in circulatory and respiratory disturbances;¹¹ extensive avascularity of central nervous tissue with reduced blood supply to the brain, muscles, and skin after dial and amytal;¹² damage of cerebral blood vessels and parenchyma after continued daily doses of barbitat;¹³ fatty degeneration of liver, kidneys, heart and lungs after nosta;¹⁴ predisposition to intercurrent disease in barbitat habitués.¹⁵ Use of barbitals in obstetrical practice is in a controversial state; more and better studies of their actions are needed. Placenta is not a barrier to barbitals, as they are readily demonstrated in the fetus, narcotized babies are not infrequent, and continued use may result in abortion.¹⁶ Dodek's¹⁷ clinical studies of uterine contractions indicate that amytal by mouth does not retard labor, but Rawlings¹⁸ states that nembutal may, and Gruber¹⁹ has reported depression of excised strips. This list is not intended to be exhaustive, but is sufficiently complete to leave no doubt of the complications which may attend the use of barbitals.

Many of the reported side-actions occur with doses of anesthetic range, some with toxic doses,

such as capillary paralysis, edema, and nerve and parenchymatous degenerations. While most of the actions have been demonstrated in animals, there is every reason to believe they can occur in humans. They should be given careful consideration in connection with clinical uses, especially the intravenous. It should not be forgotten that man is generally more susceptible to hypnotic drugs than are animals, and therefore reacts to smaller doses.

Collectively, these actions emphasize the fact that the barbitals cause widespread depression or paralysis of living tissues in varying degree. In other words, they cause general protoplasmic poisoning, and are not as selective in their actions as is sometimes claimed. It follows that the use of barbitals, as aids in systemic or local anesthesia, is fraught with certain dangers and that there is no such thing as a nontoxic sedative or anesthetic which may be used with impunity. Some of the side-actions might easily obscure or confuse a diagnosis, and affect a patient's recovery from a disease in which the barbitat was exhibited merely as a symptomatic or palliative measure. Conceivably, some of the side-actions might be desired or even useful, such as ganglionic depression in controlling reflex excitability, vomiting, asthmatic attacks, etc. On the whole, however, they are probably always objectionable in connection with the ordinary uses of barbitals. They should always be kept in mind in relation to the general condition of a patient. The high order of efficiency of some, such as evipal, is apparently related to their paralytic potentialities.

TREATMENT

The minor side-actions do not necessarily require treatment. The major phenomena approaching or resulting in collapse necessitate attention. The general depressant effects of the barbitals call for measures used in the treatment of collapse. Stopping of the medication is first in order. Removal of the barbitat, when swallowed, by gastric lavage with warm potassium permanganate (1:1000) should be attempted. Alkalies should not be used, as they promote solution and absorption. Charcoal, four tablespoonsful for an adult, is given after gavage and not removed. Apply external heat; raise the head to avert bronchopneumonia; catheterize, if necessary, and save urine for barbitat test. Dextrose solution, 5 per cent, or ammonium chlorid, 1 per cent, in physiologic salt solution may be given gastrically, hypodermically, rectally, or intravenously; this promotes diuresis and excretion of barbitals. For circulatory and respiratory depression, caffeine 0.5 gram, strychnin 1 milligram, or digitan 1 cubic centimeter hypodermically; tyramin 50 milligrams or neosynephrin 50 milligrams, hypodermically or intramuscularly, in preference to epinephrin, which is too fleeting in action, and to ephedrin, which depresses the heart; carbon dioxid-oxygen inhalation. The new antidotes, picrotoxin and metrazol, together, as powerful central stimulants, are being tried clinically with some success;²⁰ picrotoxin intravenously, in single doses of 10 milligrams up to a total of about 160 milligrams, and metrazol

intravenously, in single doses of 400 milligrams up to a total of about 2500 milligrams, in twenty-four to forty-eight hours, both drugs to be used cautiously. Cautious use of physostigmin, 0.5 to 2 milligrams, should promote restoration of vagal, gastro-intestinal and muscular functions. Intravenously injected, barbitals are not retrievable, but the various systemic, resuscitative, and excretory measures should be used vigorously. Cerebrospinal drainage may be tried to relieve pressure and to remove barbital when coma is present.

CONCLUSIONS

Barbitals are capable of producing widespread depression and paralysis of living tissues. In other words, they cause general protoplasmic poisoning, and are not particularly selective in their actions. Many of these actions are to be regarded as undesired side-actions accompanying the use of ordinary doses, others are the result of continued and extratherapeutic or toxic doses. Attention should be given to the side-actions, and caution exercised in the clinical use of barbitals. Treatment of the major depression and toxic phenomena is outlined.

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DISCUSSION

C. H. THIENES, M. D. (Department of Pharmacology, University of Southern California, Los Angeles).—Professor Hanzlik's article should be especially important to surgeons and anesthetists, for his summary of the literature on the side actions of the barbituric acid derivatives is remarkably complete. I wish to add, however, one more item to the list, namely, the tremors and clonic convulsions frequently seen in evipal anesthesia, but not referred to in the literature that has come to my attention. In experimental animals, such tremors, closely simulating the shivering due to a cold environment, are produced by amytal, pentobarbital and other barbiturates. In the human, as well as in animals, increasing the dose abolishes the tremor, but such dosage increase is often hazardous.

There is no agreement among surgeons and anesthetists as to the values and dangers of the preanesthetic use of compounds of this class. For example, many urologists have abandoned the use of barbiturates preceding spinal anesthesia, while the majority of gynecologists insist on such premedication. There is some experimental basis for the use of barbiturates as premedication for inhalation anesthesia, especially ethylene and nitrous oxid, and for procain or cocain. Pontocain and nupercain are gaining popularity, but interest in the possible value of barbiturate premedication for these anesthetics is almost wholly lacking.

Sound clinical evidence for the safety and value of barbiturate medication preliminary to spinal anesthesia is greatly needed. Parallel studies will have to be made in large clinics, with and without premedication, using similar types of case in ample numbers, before a choice of preanesthetic procedure can be established with confidence.

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C. D. LEAKE, Ph. D. (University of California Medical School, San Francisco).—With the increasing use of barbitals, and with the increasing commercial pressure behind the attempted clinical introduction of new ones, Professor Hanzlik's warning regarding their unappreciated side-actions is most timely. While the characteristic effect of the barbitals is to depress the central nervous system, physicians must remember that, in applying this fact to the relief of insomnia, they are also bound to depress other tissues of their patients. The barbitals are not selectively depressant to the central nervous system as is commonly believed. Professor Hanzlik has clearly indicated the wisdom of considering all phases of the action of any drug in applying such action clinically.

Much is being made commercially, in the rapid recovery from central depression, of such new barbitals as "pento-

barbital," or "nembutal," and "evipal." There is strong likelihood that some of the undesired side-actions mentioned by Professor Hanzlik may greatly outlast the central depressant effect. Dr. Mary Montgomery, in our surgical laboratory, has clearly shown how the salivary and gastric secretion may be greatly depressed for several days after recovery from an "amytal" narcosis (*Proc. Soc. Exper. Biol. Med.*, 32:1287, 1935). This observation affords further evidence in support of Professor Hanzlik's thesis.

✻

FRED B. MOOR, M.D. (312 North Boyle Avenue, Los Angeles).—The autonomic nervous control of the heart lends itself well to a pharmacodynamic demonstration such as Doctor Hanzlik has so clearly presented. Utilizing this mechanism, the author has shown that the barbiturates depress the autonomic ganglia, both parasympathetic and sympathetic, in a manner resembling nicotine. There is associated with this a direct depression of cardiac muscle. Koppanyi and his associates have demonstrated similar depression of the nerve supply of the heart with several other members of the barbital group.

Again, in the isolated intestine, muscle and sympathetic and parasympathetic innervation are all depressed. Probably of more significance is the fact that Gruber and others were able to produce the same depression of the intestine in the intact animal with dosages of the barbitals which fall within the range of human anesthesia. We may assume, therefore, that definite depression of the visceral and nervous elements of the cardiac and gastro-intestinal mechanisms occurs with the intravenous injection of the barbital derivatives in the human.

Fortunately, the use of the longer-acting members of the barbital group, such as sodium amytal and pentobarbital sodium, has waned. The popularity of the shorter-acting ones, such as evipal and pentothal, seems to be growing. Some anesthetists manifest considerable enthusiasm for the latter in spite of occasional serious reactions. They are convenient for various minor surgical procedures, and are usually pleasant for patients. In view of reported pathologic effects, the widespread use of even these shorter-acting barbitals does not seem desirable, at least not until they have been given more study. Once injected they are beyond recall, and are not susceptible to the same control as inhalation anesthetics.

The intravenous injection of the barbiturates may be life-saving in poisoning by strychnin and the local anesthetics. In the case of the latter, however, smaller prophylactic oral dosage should precede the local anesthetic.

LEAD ENCEPHALITIS

PRECIPITATED BY ACUTE INFECTION

By RALPH E. NETZLEY, M.D.
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DISCUSSION by Hartzell H. Ray, M.D., San Mateo; Phillip E. Rothman, M.D., Los Angeles; E. J. Lamb, M.D., Santa Barbara.

THERE is a striking tendency for children with lead poisoning to develop an encephalitis which has a poor prognosis. Because of its relatively frequent occurrence, the preventive aspect of the problem should be greatly stressed.

It has been observed that children may ingest small amounts of lead over a prolonged period of time without manifestation of symptoms. Intoxication following the ingestion of lead appears to be dependent on a number of factors. Of primary importance is the amount of lead ingested, and the period of time over which it is taken into the body. The absorption of small amounts of lead by all persons seems to be of a normal occurrence, and is said to be unaccompanied by danger.¹ An

increase in the amount of lead ingested, or the continuation of absorption over a long period of time associated with storage in bones, gives rise to potential danger. There is observed considerable individual variation in tolerance to this metal. Some children, after the ingestion of moderate amounts, rapidly develop encephalitis. Others are capable of tolerating quite large amounts with minimal development of symptoms, but, however, with the deposition of abnormal amounts of lead in the bones.² Under certain circumstances, such as the occurrence of acute infection, the chemistry of the body may be changed in such a way as to cause the mobilization of the lead deposited in the bones in apparently inert form, and thereafter develop an acute intoxication. Lead is carried in the blood stream presumably as the phosphate, and is deposited in various organs, especially the bones, brain, liver, and pancreas. Lead deposited in the brain will cause central nervous symptoms. The severity of symptoms will vary with the quantity and rapidity of deposit. These symptoms of encephalitis may be the first indications of lead poisoning precipitated by an acute infection.

REPORT OF CASES

Four cases of lead encephalitis studied at the Pasadena Hospital were initiated by such infections as otitis media, mastoiditis, tonsillitis, and pertussis. None of these children, according to accurate histories, showed significant signs or symptoms of lead poisoning prior to the acute onset of the above mentioned infections. During the course of these infections, three of the four children developed violent convulsions, vomiting—frequently of the projectile type, threatening respiratory failure—and symptoms of cerebral edema. The fourth child only developed tremors, occasional vomiting, and gastro-intestinal disturbances. These children showed characteristic changes in the appearance of the red blood cells, excess amount of lead in the urine, lead lines at the ends of the diaphysis by x-ray, and spinal fluid under increased pressure.

Three of these children are living, two of whom have no apparent symptoms of lead poisoning. The third child, originally treated for otitis media, now has an ataxic gait, shows behavior changes, and has marked mental deterioration. The fourth child, originally having pertussis, died after one week of violent convulsions and symptoms of marked cerebral edema. Autopsy showed relatively large quantities of lead in most of the organs of the body, especially the brain tissue. This child died at the age of nine months.

The source of lead in two of the children was undetermined. In the other two children lead was ingested from play-pen and crib.

DIAGNOSIS

A diagnosis of lead poisoning can be made in children in the early stages of intoxication by the correlation of the history, physical signs, and laboratory data in conjunction with x-ray findings. The clinical picture is the usual one seen in lead poisoning—vomiting, abdominal pain, anemia, central nervous system symptoms such as irritability, ataxic gait, stupor, twitching or convulsions, peripheral nerve lesions, and sometimes behavior changes. Lead encephalitis must be distinguished from other types of diseases with cerebral involvement, notably various forms of encephalitis and meningitis. It is the opinion of McKhann and others that the cerebral manifestations are evidences only of the cerebral edema, and not pathogenic of lead intoxication.

BLOOD PICTURE

The blood picture varies according to the amount of lead assimilated and the amount of lead circulating in the blood in a given period of time. The usual blood picture is a moderate, secondary anemia with basophilic stippling of the red cells. Lead, phosphorus, and bichlorid of mercury are at times the cause of a severe anemia, but the only poison which gives a characteristic change in the appearance of the red blood cells is lead, which produces a striking heavy basophilic stippling of the erythrocytes. The anemia of lead poisoning is usually very chronic in contrast to such violent poisons as phosphorus or bichlorid of mercury.

Stippled red blood cells are found in pernicious anemia, lead poisoning, and malaria. They are less constant and less numerous in the leukemias and in the cachexias referable to septic infections, syphilis, carcinomatosis, and in the final stage of tuberculosis. The largest granules are found in pernicious anemia and in cases of lead poisoning.

SPINAL FLUID

The cerebral spinal fluid is usually clear, and escapes under increased pressure—often as high as 700 millimeters of water pressure. Cells are somewhat increased, from 60 to 100, mostly lymphocytes. Protein is definitely increased quantitatively up to 150 to 200 milligrams. The sugar is normal to high, relatively and absolutely, and the chlorids are normal (Lyttle).

X-RAY FINDINGS

Roentgenograms may show the bones at the ends of the diaphysis to be quite dense. These findings have been described in the literature as signs of lead poisoning.^{3,4,5} This change in the bones has proved to be one of the most constant signs of lead poisoning in children, and has led to the discovery of numerous cases with minimal symptoms or with unusual clinical manifestations. Heavy lines in the ends of long bones are not peculiar to lead poisoning, as the ingestion of phosphorus and other substances may produce similar lines.⁶ Occasionally, in the normally growing child there may be a zone of increased density at the metaphyseal margins of the long bones, owing to a heavy deposit of calcium. These lines should not be confused with the lines observed in lead poisoning, which are of greater density. Narrow lines, of sufficient density to be confused with a lead line, may be found at the ends of long bones in healing rickets, and in infants with vitamin A deficiency.

LABORATORY FINDINGS

Further confirmation of the presence of lead in the cerebrospinal fluid may be obtained by spectroscopic examination.⁷

Examination of urine and stools by a competent technician, for lead will confirm the diagnosis of lead poisoning. However, the demonstration of lead in the excreta of children, by chemical examination, is not conclusive evidence alone of lead intoxication.⁸ Children with lead poisoning excrete much larger amounts of the metal than do

normal children, so that quantitative determination of lead in the excreta, properly controlled, may be accepted as satisfactory evidence of lead poisoning.

TREATMENT

Lead in the body is absorbed, transported, deposited, and excreted much as is calcium. Therefore, in general, factors which influence calcium metabolism might be expected to have an influence on lead. These observations have been made by Aub and his coworkers.⁹ Lead deposited in the organs of the body may induce the symptoms referable to the various organs or systems, while lead deposited in the bones is in an inert form. This treatment for lead poisoning involves measures to remove the lead from circulation and deposit the metal in the bones. Calcium salts or phosphates¹⁰ are administered to diminish the solubility of lead in the blood. The milder cases of lead intoxication may show improvement if the ingestion of lead is prohibited, and if the child remains free from infection and acidosis. Efforts of deleading the bones have resulted in the recurrence of cerebral symptoms. Therefore, allowing spontaneous elimination of the metal is probably more satisfactory treatment. Besides the administration of calcium intravenously, normal salt solution and intravenous glucose may be given to relieve acidosis. Intravenous injections of magnesium sulphate to relieve cerebral edema may be useful, but are only temporary measures. Intracranial pressure caused by cerebral edema probably accounts for the permanent cerebral injury that is so common among children who survive the acute encephalitic stage.

SUMMARY

1. Lead is stored in the bones of the body in an inert form.
2. This lead may be released and cause an acute intoxication by means of the changes in body chemistry, caused by an acute infection.
3. Basophilic stippling of the red cells, increased amounts of lead in the urine, lead lines in the x-ray of the long bones in conjunction with the usual physical signs of plumbism, make the diagnosis.
4. The treatment is directed at replacing the lead in the bones in its original inert form.
5. Possibly unrecognized plumbism in children explains many convulsions of undetermined etiology.

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DISCUSSION

HARTZELL H. RAY, M.D. (23 Second Avenue, San Mateo).—In young children the diagnosis of lead encephalitis is often missed because this clinical entity is not thought of. A child who is irritable, cries a great deal, has a slight change in personality, and who may have some bowel disturbance, should be a suspect of this disease.

The pediatrician has the greatest responsibility, also the greatest opportunity, in this disease to practice good preventive medicine. Advice to mothers to get beds that are stained instead of painted; the avoidance of lead-painted toys, and the discouragement of buying lead-containing colored crayons. Occasionally, where plumbing is old one may want to investigate such things as the matter of lead pipes and the amounts of lead in the drinking water. One may find in certain houses that lead pipe has been used from the main into the house, and may or may not be a source of trouble.

During a recent epidemic of lead encephalitis it was reported that lead-containing battery boxes were used for fuel, which brings out another interesting source for lead absorption. The pediatrician can advise mothers about a great many of the common playthings and objects, which may be a source of lead and cause trouble if sufficient amounts of lead are ingested by the children.

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PHILLIP E. ROTHMAN, M.D. (3875 Wilshire Boulevard, Los Angeles).—The early demonstration that the metabolism of lead simulates that of calcium has been misinterpreted in its application to the therapy of lead poisoning. Shelling has pointed out that the administration of calcium salts, other than the phosphate, for the purpose of storing or "driving" the lead into the bones, where it remains in an innocuous state, may actually result in an accentuation of symptoms if the ratio of calcium to phosphorus is abnormally increased. Since defective ossification may occur from a diet which renders the calcium level high and the phosphorus low, or vice versa, superior calcification and likewise lead storage demand the maintenance of a definite ratio between calcium and phosphorus. Adequate amounts of phosphate are necessary to enable the lead to be deposited as the insoluble lead phosphate. The results, experimentally and in human beings, have been more satisfactory with phosphate therapy than with any other form.

The use of vitamin D therapy in lead poisoning is particularly dangerous, since it not only increases the concentration of calcium and phosphorus in the blood, but also that of circulating lead. It may be used cautiously when the diet is not excessive in calcium and only in conjunction with three grams daily of disodium acid phosphate. Shelling has called attention to the interesting observation of the seasonal incidence of acute lead poisoning. The majority of cases occur during the summer months, when the sun's rays emit an abundance of ultraviolet. This apparently increases the toxicity of the ingested lead in the same way that results from the oral use of viosterol.

E. J. LAMB, M.D. (1515 State Street, Santa Barbara). Doctor Netzley's paper should bring to the pediatricist's attention the possibility of lead poisoning as a cause of convulsions of unexplained origin.

With the present flood-tide of biochemical literature on hypoglycemia, hypocalcemia, etc., as a causative factor in convulsions of childhood, one is apt to neglect inorganic chemical poisoning as a cause of convulsions.

My personal experience with lead encephalitis is very limited—too limited, perhaps, to enter the discussion of this excellent paper.

I have treated only one case, a male of four years of age, who became hospitalized at a contagious hospital with chickenpox. During his sojourn at the hospital his toys were limited to those articles which could be washed in a solution of lysol. Consequently, this child was continually playing with little inanimate soldiers and horses made out of lead. With desquamating macules and pustules it is readily believed that he absorbed through his denuded skin an appreciable amount of lead. Preceding the lethargy of encephalitis, this patient complained of severe abdominal cramps, unaccompanied by any gastrointestinal upset, evidently lead colic.

Unfortunately, the only laboratory test to confirm a diagnosis of plumbism was the basophilic stippling of the red-blood cells.

Whether the child's encephalitis was a complication of chickenpox, or a symptom of plumbism, is a matter of conjecture.

This child at present, two years later, shows a definite mental retardation and poor muscular coordination.

Years ago lead water-pipes were a source of lead poisoning. Today lead toys must be considered as a possible source.

CLINICAL ADRENAL INSUFFICIENCY

By ALFRED C. REED, M.D.
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DISCUSSION by Hamilton H. Anderson, M.D., San Francisco; Roy E. Thomas, M.D., Los Angeles.

THE clinician sees, not infrequently, patients who complain of asthenia, anorexia, easy tiring, palpitation, languor, variable abdominal pains, often unexplained nausea, vomiting and diarrhea, with no evident reason apparent on physical examination. Various functional symptoms are present. The systolic blood pressure is below normal. The basal metabolism is little, if any, depressed. Careful search for psychogenic factors is unrewarded. The organic structure shows no constant abnormalities, and the diagnosis of neurasthenia often seems inevitable and equally unsatisfactory.

In a group of such patients, chiefly young women, we have found some who showed lowered blood sugar, decreased blood sodium chlorid, and a striking lack of response to ordinary tonics, forced feeding, abdominal support, and a tonic regimen. Many of these are intolerant of thyroid extract, and show no improvement with various pituitary preparations. Some show remarkable improvement when large amounts of sodium chlorid are added to the diet, and especially when this is combined with reduction in dietary potassium. The administration of adrenal cortical extract is most striking in its results and more lasting in its effects than any other measure. When cortical extract is used, dietary and other measures become of adjuvant or supplementary value only.

It seems logical to expect that adrenal deficiency may exist in all degrees short of the picture of

Addison's disease, and that such deficiency may follow other causes than organic destruction of cortical substance. The characteristic disturbances in blood chemistry obviously will appear in various degrees also. The success of substitution therapy is a factor in correct diagnosis. Maximal treatment includes a course of injections of cortical extract, high salt intake in diet, and the administration of ephedrin by mouth. The latter two alone are poor substitutes for cortical extract, but may be valuable as adjuvants.

CLIMATIC RELATIONS

The question arises as to the relation of adrenal depression to hot climate. Excessive perspiration tends to deplete the blood sodium chlorid. Monotony of warm temperature tends to lower the blood pressure. When external conditions interfere with heat loss, the way is paved for the clinical syndrome of sunstroke. Cramer¹ has made a suggestive study of this condition, using in animals injections of beta-tetra hydronaphthylamin which gives prolonged sympathetic stimulation with overactivity of the thyro-adrenal apparatus. The increased heat production, combined with decreased heat loss (high environmental temperature), produces what he calls "sympathetic fever." The degree of this fever depends chiefly on the environmental temperature and cooling capacity. He found, postmortem, the same pathologic changes as in hyperpyrexial heat stroke in man. There was also a corresponding similarity in symptoms. Cramer explains the situation as being due to the action of an extrinsic factor (*i. e.*, insufficient cooling) on an organism which is under the influence of excessive stimulation of the thyro-adrenal apparatus.

Under conditions of monotonous hot climate, long-continued overstimulation of the adrenals may also be replaced by insufficient stimulation or exhaustion. This, combined with enervating infections and habits, easily becomes a major factor in the development of disturbances in the autonomic nervous system and of so-called tropical neurasthenia. There is need for careful study of adrenal function in the tropics, with the possibility that the proper use of dietary salt, ephedrin and adrenal cortex extract may prove of unsuspected therapeutic value.

De Langen and Lichtenstein² discuss in detail what they call "essential hypotension" in the tropics. They list the principal symptoms as headache, dizziness, anxiety, palpitation and precordial pain and extreme fatigue. They also note abdominal pain, nausea, vomiting, and diarrhea. Apparently, without direct evidence, they ascribe the condition to climatic atony of vessel walls. They find commonly a decrease in blood sodium chlorid and blood sugar. Certainly, adrenal insufficiency comes seriously into account, and further study is greatly needed from this point of view.

BLOOD CHEMISTRY

Grollman,³ in his complete and excellent book on the adrenals, summarizes the known changes in blood chemistry in adrenal insufficiency. He

surveys experimental work up to date on animals, noting that Marshall and Davis⁴ in 1916 observed in adrenalectomized cats a rise in non-protein nitrogen, especially in the urea. The conclusion was that normal renal function depends on the integrity of the adrenals or on a product of their secretion. Grollman notes the abundant confirmation of these findings by later writers. He states that rise in non-protein nitrogen is one of the earliest manifestations of adrenal insufficiency, appearing before such symptoms as weakness and anorexia. Death may occur from adrenal insufficiency with a non-protein nitrogen reading in the blood of only twice the normal figure, indicating that death is not due merely to this increase, since much higher levels can occur without death, as after ureteral ligature, for example.

In dogs, Grollman found a consistent and progressive increase in the blood of non-protein nitrogen, cholesterol and potassium, with a corresponding decrease in sodium chlorid and dextrose. The pH of the blood tended to decrease, with greater rapidity toward the end.

Zwemer and Sullivan⁵ attempted to find a criterion for measurement of the level of activity of the adrenal cortex. Using cats, they found that adrenalectomy was followed by an early loss of sodium, which was reflected in lowered CO₂ capacity with an increase in potassium and non-protein nitrogen. Before death there was also a decrease in blood sugar and chlorid with higher figures for phosphorus and magnesium. They found no important changes in the calcium. They describe the clinical syndrome as seeming to consist of disturbed metabolism of salt and water, with loss of water and depletion of blood chlorid and sodium, together with an increase of blood potassium. Injection of cortical extract into adrenalectomized animals reversed the changes of adrenal insufficiency, and favorably affected observable symptoms. They suggest that the cortex produces a secretion which enables body cells to metabolize salt and water.

In a later paper, Zwemer⁶ reviews these findings, noting that all of the body symptoms indicate changes in body fluids, and concentration of the blood with increase of blood solids, and dehydration. The loss of water takes place chiefly through the kidneys and probably also by reason of the diarrhea so common in early stages. It is further increased by vomiting. Zwemer cautions against drastic relief of constipation in late adrenal deficiency. He suggests that the rise in potassium may be due to its withdrawal from the tissues. Apparently in the plasma, potassium cannot replace sodium without a fatal result. Sodium chlorid gave a definite extension of the survival period in adrenalectomized cats.

Rise in blood potassium has been reported frequently in experimental adrenal deficiency and in the crises of Addison's disease. As noted above, Zwemer and Sullivan⁵ found that injection of cortical extract lowered the high blood potassium level. Zwemer and Truszkowski⁷ state that increased blood potassium might arise from hemolysis of red cells, or as a result of repeated bleeding.⁸

In experimental work on cats, these authors eliminated these two possible errors, and reached the conclusion that "an important function of the adrenal cortex is the regulation of potassium metabolism, and that the various known symptoms of cortico-adrenal insufficiency may be explained in terms of a disturbance of cortico-adrenal-potassium interrelations." They further state that "depletion of sodium may be ascribed to the diuresis due to high potassium" (referring to Blum, Aubel, and Levy.⁹) Low blood sugar has been observed after injection of potassium (referring to Kylin and Engel.¹⁰) Muscular weakness has long been known to be associated with high blood potassium. . . . Dehydration of the blood, often reported in adrenal insufficiency, may be considered a consequence of diuresis and stasis. Finally, the lesions found in the kidney in potassium poisoning are of the same type as those in adrenal insufficiency." They suggest that in Addison's disease elimination of dietary potassium may be more important than to add sodium chlorid. Truszkowski and Zwemer¹¹ have recently prepared a new method for determination of potassium in 0.2 cubic centimeter of blood taken from the ear. Camp and Higgins¹² believe that most of the results produced by epinephrin are really due to potassium. Crabtree and Longwell¹³ have shown that in rats a diet rich in sodium chlorid was accompanied by a large increase in liver glycogen.

TREATMENT

When a condition of adrenal deficiency has been seriously suspected or diagnosed, the first consideration in treatment should be the hypodermic administration of cortical extract. We have given one cubic centimeter daily of cortical extract¹⁴ for ten consecutive days. Supplementary to this, sodium chlorid should be greatly increased in the diet. Usually 8 to 16 grams (two to four teaspoonfuls) can be taken daily as an addition to food. Benefit may be derived from administration of ephedrin sulphate orally (0.015 to 0.040 gram) two or three times daily, in place of cortical extract or as an adjuvant to it. In more serious cases it may be desirable to eliminate from the diet, or to decrease, those foods having a relatively high potassium content. The commoner foods rich in potassium are listed as follows:

Apple	Cocoa
Apricot	Chocolate
Banana	Meat extract
Dates	Mustard
Figs	Caviar
Olives	Kidney and Lima beans
Peaches	Sweet and white potatoes
Prunes	Spinach
Raisins	Dried peas
Peanuts	Green cabbage
Coconut	Beets
Almonds	

Failure to secure disappearance of symptoms indicates incorrect diagnosis, and complete success of treatment is of strong confirmatory diagnostic value.

Several condensed illustrative case reports are appended.

SUMMARY

1. Subclinical Addison's disease, or various stages of adrenal insufficiency, are seen clinically.

2. Such cases do not always exhibit all of the symptoms of adrenal insufficiency, so that response to treatment becomes of diagnostic value.

3. Adrenal dysfunction may play a significant rôle in tropical neurasthenia and in hyperpyrexial heat stroke (sunstroke).

4. In adrenal insufficiency, subjective symptoms are associated with characteristic changes in blood chemistry, which are described.

5. The relation of potassium to adrenal function, while not finally evaluated, is very suggestive, and gives therapeutic indications of possible value.

6. Treatment is outlined, using cortical extract, sodium chlorid, ephedrin, and low potassium dietary.

REPORT OF CASES

CASE 1.—Mrs. I. S. Aet. 42. For fifteen years the outstanding complaints have been weakness, easy tiring, and exhaustion, which are more intense in the early morning and tend to improve toward evening. Since acute appendicitis with drainage at the age of fifteen, she has had frequent periods of pain in the right lower quadrant, ascribed to adhesions. She has three children. Constipation, with frequent periods of diarrhea, has always been present. Various minor complaints have received treatment.

Examination showed an asthenic undernourished woman, with weak spine and feet, and ocular muscle imbalance. She said she had always been "double-jointed." The skin was unusually dry and thick, with some patches of squamous eczema. There was tenderness in the right lower quadrant. The blood pressure average was 100/70, often registering at 90 to 94 systolic.

X-rays of gastro-intestinal tract, teeth, sinuses, and spine were negative. Basal metabolic rate averaged minus 5. Repeated stool examinations showed no parasites. Blood, urine, and Wassermann reaction were negative.

Diagnosis.—Adrenal and probably pituitary deficiency.

Course.—Extensive use of ordinary tonics and combinations of thyroid and pituitary extracts gave, at the most, transient improvement. Addition of 12 grams of salt to the diet daily gave definite improvement, but soon interfered with appetite and digestion. A course of adrenal cortical extract, one cubic centimeter daily hypodermically for ten days, gave a complete and dramatic restoration to normal health, which has now lasted for six months. Small doses of ephedrin have been continued. All eye symptoms have disappeared, and her strength and energy are at their best in many years. The blood pressure averages 110 to 116 systolic.

CASE 2.—Miss B. D. Aet. 20. The patient has for four years suffered from increasing palpitation and tachycardia, with much emotional instability. At times she has been free of symptoms. Weakness, easy tiring, and inability to exercise have been prominent. At times she has had severe headaches. Severe anorexia and occasional nausea are present. She slept poorly. Dysmenorrhea has been severe. Lately she has lost nine pounds in weight. She has had many infections, chiefly repeated colds, otitis media, and sinusitis. The appendix was removed at age of twelve. She had used tobacco to excess.

Examination showed a systolic blood pressure averaging between 82 and 94. The blood and urine were normal. Basal metabolic rate was 16 plus.

Diagnosis.—Adrenal insufficiency.

Various upper respiratory infections.

Course.—Addition of extra salt in diet gave only slight improvement. One cubic centimeter of eschatin hypodermically daily for ten days resulted in a rise of blood pressure to an average of 108 to 112. She gained in weight, appetite became normal, and other symptoms disappeared.

CASE 3.—Mrs. E. R. Aet. 31. The patient complained of exhaustion, easy tiring, and languor. Exertion caused palpitation and faintness. She has had more or less of such symptoms for many years. She was underweight, showed much vasomotor instability, and frequent attacks of diarrhea, often with nausea. The systolic blood pressure was recorded between 92 and 106. Abdominal pain was often present.

X-rays of chest and spine were negative. No abnormality was found in blood, urine, or stools. Wassermann reaction was negative. Blood sugar was 85 milligrams per cent. Blood sodium chlorid was 460 milligrams per cent. Non-protein nitrogen was 25.9 milligrams per cent.

Diagnosis.—Adrenal insufficiency.

Treatment consisted of a full diet with salt added to the amount tolerated by taste. Ten daily injections of one cubic centimeter of eschatin were given hypodermically.

Course.—All symptoms disappeared. Blood pressure rose to a systolic reading of 128.

✓ ✓ ✓

CASE 4.—Mrs. D. C. Aet. 50. Complained of vertigo, easy tiring, weakness, exhaustion, tendency to diarrhea, with some abdominal pain and spells of faintness. Palpitation was frequent. At times physical exertion caused collapse. Vasomotor symptoms have been prominent. Fifteen years ago gall-bladder disease was suspected, but never proved.

The routine laboratory findings were normal. Gastrointestinal x-rays were normal. Stools repeatedly were normal and free of parasites. Blood pressure averaged between 92 and 104 systolic. Excess salt was poorly tolerated in the diet. Ten daily injections of one cubic centimeter of eschatin hypodermically gave marked improvement in appetite and symptoms with return of strength and endurance.

✓ ✓ ✓

CASE 5.—W. H. F. Male. Aet. 47. The present illness began fifteen months ago, when he began a year's residence in Honolulu. An amebic dysentery required repeated courses of treatment through most of the year, and has now been cured. He has lost energy, tires easily and is oppressed by lassitude, both physical and mental. His bowels tend to looseness, especially in the mornings. He suffered from vertigo and dyspnea on exertion, and required two pillows at night. Palpitation was troublesome.

The history had nothing else of significance.

Examination showed an average blood pressure of 100 systolic in a thin, wiry man, weighing 122 pounds. Gastric fractional analysis was normal. Blood count, urine, and stools were normal and free of parasites. B. M. R. gave a reading of minus 4.3 per cent. Gastro-intestinal x-rays showed no evidence of organic lesion. Blood sugar was 87 milligram per cent. Blood sodium chlorid was 462 milligram per cent.

Diagnosis.—Hypo-adrenia following cured amebic dysentery.

Course.—General tonics, with intestinal astringents, and a smooth diet, gave transient slight improvement. Complete disappearance of symptoms followed a course of eschatin, one cubic centimeter hypodermically daily for ten days.

350 Post Street.

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DISCUSSION

HAMILTON H. ANDERSON, M. D. (350 Post Street, San Francisco).—The clinical diagnosis of adrenal insufficiency of a mild degree, or of frank Addison's disease, is very difficult indeed. Abnormal changes in blood-chemistry findings are the best objective criteria, but often, in early cases, such variations are not significantly marked. In those instances where the functional disturbances suggest adrenal insufficiency, a most useful diagnostic aid is substitution therapy with adrenal cortical extract, sodium chlorid and dextrose. Doctor Reed reviews the chemical changes that have been found experimentally in adrenalectomized animals. We must remember, however, that the classical laboratory picture of this severe derangement is seldom seen clinically. Because of this fact, one must be suspicious of adrenal insufficiency in any patient presenting the symptoms enumerated by the author.

In reviewing the cases reported by Doctor Reed one is especially impressed with the consistently low systolic blood pressure in every instance before specific substitution therapy was instituted. In the majority, substantial increases in the systolic pressure were obtained which paralleled symptomatic relief. However, it is interesting to note that the subjective improvement may continue after the blood pressure has returned to approximately the pretreatment level. This observation has also been made in a similar group of patients who received benzedrin therapy.

While it has not been possible to transfer directly to the clinic the laboratory findings on adrenalectomized animals, it is fortunate, indeed, that such work has led to a better understanding of the physiologic and chemical disturbances accompanying adrenal insufficiency in man.

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ROY E. THOMAS, M. D. (1136 West Sixth Street, Los Angeles).—Probably half of the patients seen by the internist suffer from no organic disease, and a very considerable percentage of this group complain of the syndrome described by Doctor Reed in this paper, with the stress laid upon one or the other of the symptoms named—fatigue, palpitation, and abdominal distress leading the list. Most of these patients have been tagged as cases of neurasthenia or thyroid insufficiency. Most of them have low blood pressure. As Doctor Reed says, only a few have low basal metabolism. Some without an abnormally low basal rate feel better while taking thyroid; others are unable to take thyroid without phenobarbital or other mild sedative. Without estimation of the blood chlorids, I have tried ephedrin in some of these cases, with temporary benefit. Possibly the addition of sodium chlorid in enteric, coated tablets, such as are used in the treatment of lobar pneumonia, would be better tolerated than salt in bulk or in capsules.

Doctor Reed may have hit upon a valuable addition to our therapeutic armamentarium. Only a larger series of cases, followed for a longer period of time, will establish its real value. I hope we may have a follow-up of these cases, with the addition of others, and records of the blood chlorids and blood sugar after treatment as well as before. Such a follow-up will be of great interest.

MEDICAL ASPECTS OF THE BUSINESS CYCLE*

By EMIL BOGEN, M.D.
Olive View

DISCUSSION by A. B. Cooke, M.D., Los Angeles; Chauncey D. Leake, Ph.D., San Francisco; Clarence G. Toland, M.D., Los Angeles.

THE belief that economic depressions and crises are accompanied by an increase in sickness and death, and especially by an increase in the incidence and mortality from pulmonary tuberculosis, is widespread.¹ A distinct note of astonishment is expressed in many recent publications at the continued decline of the general death rates, and particularly that from tuberculosis, after more than six years of economic depression; and special credit for this state of affairs has been claimed for a number of public health and social agencies. Despite the positive manner in which such statements are phrased, convincing evidence of their validity has not yet been adduced.

ECONOMIC DEPRESSIONS

A depression is such a definite phenomenon in the course of modern economic history, and has recurred so frequently in the past century, that one might expect that its salient characteristics would be readily understood. There is an abundance of reliable information available for investigation. Many of the essential facts were unearthed in the monumental study, "Special Aspects of the Business Cycle" by Dorothy Thomas, more than a decade ago,² and a better understanding of their significance would lead to a more intelligent and sympathetic attitude to the occurrence of periods of business depression.

The term "depression" is generally used to represent a condition that is almost universally hated and condemned. The most devout prayers were uttered, and the most strenuous efforts exerted for the early end of the recent economic situation. To the average man "depression" is a term of opprobrium, and all unliked characteristics are attributed to it without any attempt to confirm their appropriateness. Thus, analogies are freely made between the conditions of business depressions and wars, famines, plagues, and other calamities.

The essential characteristics of a business depression, a glutted market, business stagnation and widespread unemployment, are just the reverse of the conditions that exist during wartime and other calamitous situations. The removal of a large part of the population from productive labor in time of war, the acute shortage of commodities in famines and droughts, and the disabling and destruction of available workers by plagues and other catastrophes, all lead to scarcity, high prices and profiteering, and increased demand for labor. More than one business depression, indeed, has been terminated by such a calamity.

Commercial prosperity is by no means synonymous with the real well-being of the entire com-

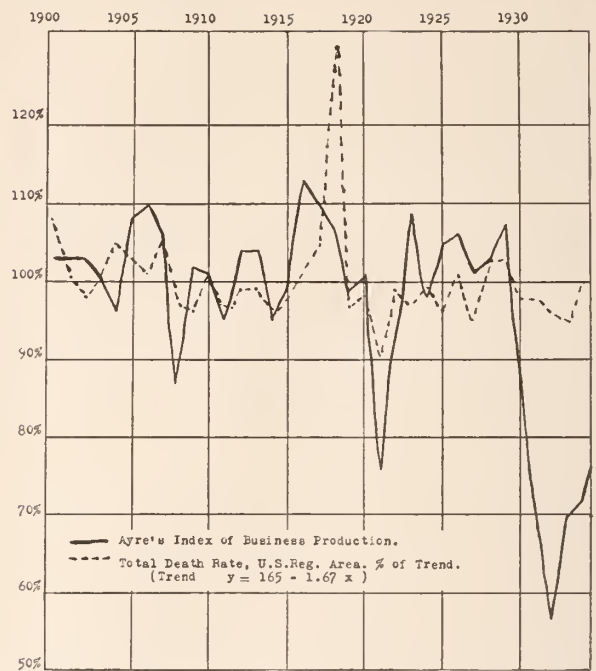


Chart 1.—The Death Rate and the Business Cycle.

munity. The disaster to the machinery of the economic organization which a depression represents may, in fact, have repercussions in other lines of human activity that are highly to be desired. That certain individuals may suffer as a result of business depression is, of course, impossible to gainsay; but all available information indicates that the health of the people as a whole, and especially their lives, are better conserved in times of depressions than in periods of prosperity.

The Index of American Business Activity from 1790 to the Present Day, published by the Cleveland Trust Company,³ is one of the longest and best known measures of the changes in business conditions in this country. Rises in this curve represent periods of generally expressed economic prosperity and business booms and expansion, while the dips below the average value correspond to panics, crises, declines and depressions in business, which are reflected in the descriptive language of history and the public press. Although there are many other indices of business activity which might be used, which vary in absolute values, the location of the rises and falls practically correspond, and there is very little difference of opinion as to just when the periods of prosperity and of depression in American business occurred.

GENERAL MORTALITY RATES

The easiest and most accurate information obtainable about any population group is the death rate. There are many factors affecting this, but the influence of a single important agent, such as war, an epidemic, or other catastrophe, is so sharp-cut and definite that depressions, if they had any marked effect on the general health, could well be expected to manifest this through some change in the death rate. Thus, the rise in the death rate in practically all countries during war, the

* Read before the meeting of the Southern California Medical Association, October 31, 1936.

PHTHISIS AND PROSPERITY

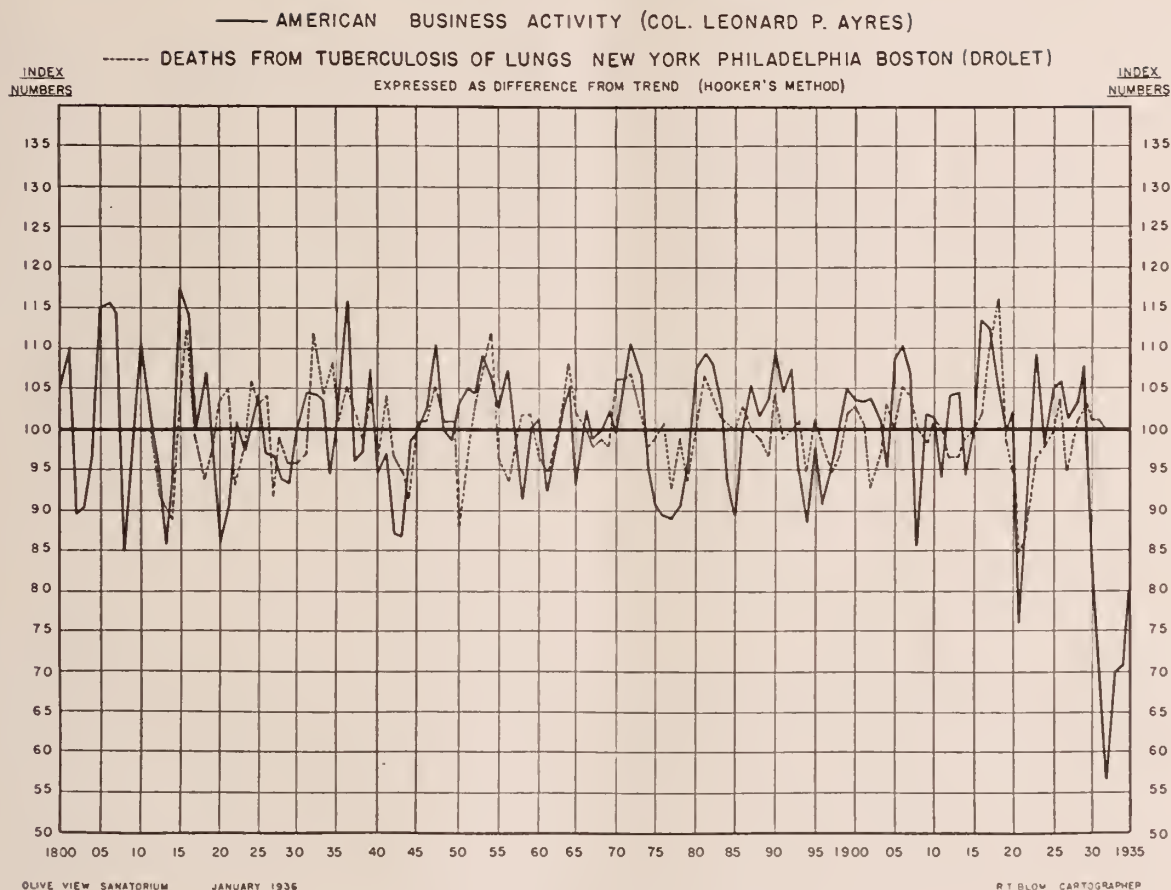


Chart 2.—Phthisis and Prosperity.

increased death rate with each influenza epidemic, and the increased death rate accompanying famines, droughts or floods in Europe and Asia, are prompt and unmistakable.

In the United States the death rates for the expanding registration area are available since 1900.⁴ When these are compared with such an index of business conditions as that described above, the fatal cost of business prosperity becomes evident, and the life-saving value of a cessation of commercial activity is revealed. Casual inspection of the crude figures shows that the sharpest drops in the mortality rates followed the beginning of economic declines, while the actual rises, as well as the cessation of the usual trend to lower rates, accompanied periods of business booms.

Refined statistical analysis merely reinforces this conclusion. Both the classical product moment coefficient of correlation of Pearson, and the simpler coefficient of concomitant variation of King appear positive and equal to many times their own probable error. Not only in this country, but in England and Wales, and wherever such data is available in modern industrialized civilized communities, not only for the recent depression, but for each of the commercial cycles of the past century, the general death rate goes down, and not up, in times of depression.⁵ A short depression is

accompanied by a brief decrease in the death rate, while a long depression is accompanied by a prolonged decrease, excluding the possibility of a delayed reverse effect.

TUBERCULOSIS DEATH RATES

Occasionally it is suggested that people live too well and eat too much in times of prosperity, and the reduction in the diet and resumption of harder living conditions may be responsible for the decrease in the death rate observed. Such moralizing, however, is refuted by a closer examination in the death rates from different causes. Clinical experience, for example, has shown that undernutrition is closely associated with the appearance and progression of tuberculosis, and that the death rate from this condition can be appreciably reduced by an increase in the diet. The spectacular increase in the tuberculosis mortality rates during the war demonstrate this effect; but it must be remembered that every index of business, production and employment shows that this was a period of high prosperity, just the reverse of the conditions of economic depressions we are discussing.

The tuberculosis death rate is available for the large American cities of New York, Boston, and Philadelphia for more than 120 years.⁶ Analysis of this curve, covering nearly the entire life of our in-

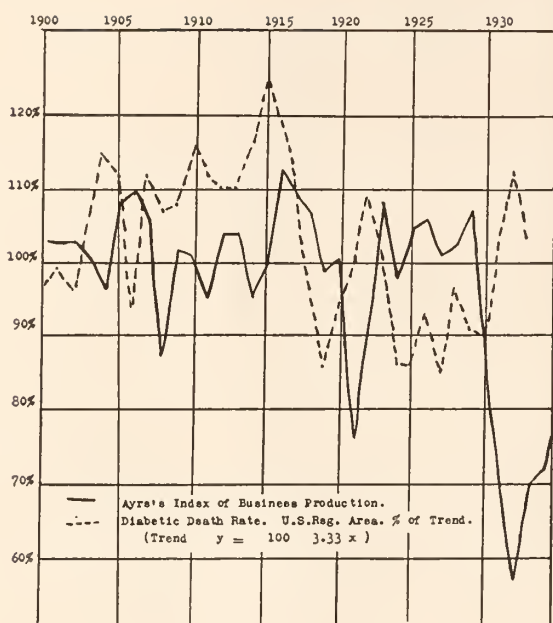


Chart 3.—Diabetes and the Business Cycle.

dustrial civilization, as compared with the curve of business activity for the same time, shows unmistakably that tuberculosis increases in times of prosperity and decreases in times of depression. The coefficient of correlation between the two series is plus 0.42 with a probable error of 0.05, evidencing the real significance of this relationship. To satisfy the Job's comforters who still insist that the ill effect, although absent in the same year as the depression, is sure to appear in the following years, it is interesting to note that no matter whether we lag the curve by one, two, three, four, or even five years, we are unable to obtain any evidence that such a catastrophe as has been predicted will occur.

CAUSATIVE FACTORS

It has been suggested that the increased use of alcohol and other forms of dissipation during times of prosperity may account for some of the increased mortality rate noted. Increase in traffic and personal contacts, with consequent greater opportunities for exposure to infection, have also been mentioned. The greater nervous strain of boom times, the more active physical and mental exertions then required, and the disposition to let down and rest during depressions are also given as possible causes. It has also been speculated that, as tuberculous individuals might be the first to be let out of employment when business declines, and the last to be reemployed during the boom following, the compulsory rest so inflicted may naturally go first to the very individuals who need it most.⁷

Further study indicates, however, that it is not only the high tension of economic prosperity that exacts its toll of victims of Mammon, but that the indices of commercial prosperity in terms of the stock market, rising profits and prices, and expanding industry are actually inversely related to the true physical well-being of the masses of



Chart 4.—Meat consumption and the Business Cycle.

the population. "Good times" from the point of view of the business man and the classical economist is by no means the "time of plenty" for the people. Again, let us recall that war, drought, famine, and plague are historically associated with underproduction, high prices and labor shortage, while bumper harvests, peaceful industrial development and general good health lead to excess supplies, low prices, and glutting the labor market. In plain English, despite the almost universal popular belief to the contrary, people eat more in times of depressions and, therefore, are healthier, and eat less in times of commercial prosperity, and therefore die of tuberculosis and other diseases of undernutrition.

DIABETES AND DIET

Corroboration of this finding may be sought in the data regarding diabetes, a disease traditionally associated with overeating. During the war-time prosperity and postwar food shortage in the central and eastern European countries, the diminution in the incidence of diabetes was repeatedly remarked. In this country the death rate from diabetes, which has been increasing since 1900, shows fluctuations from this general trend which are quite different from those discussed above in the general death rate, and that from tuberculosis. Diabetes seems to decrease in periods of prosperity and increase in times of business depression. This again strongly suggests that actually people eat more during depression years and less during times of commercial prosperity. It is obvious that we may look to the statistics of food production and consumption in various years to see whether this is really the case.

ACTUAL FOOD CONSUMPTION

The per capita meat consumption in the United States, as given in the World's Almanac⁸ for the past quarter of a century, shows unmistakable con-

firmation of the conclusion based upon the vital statistics. Although there has been a general downward trend in the per capita consumption of meat in this country for a long time, fluctuations from this trend reflect those of business activity. During prosperity, meat consumption tends to decline; during depressions it tends to rise.

The index number of the purchasing power of wages of union workers as measured in terms of food is available for the past two decades. Here also we find that the food value of union wages has run inversely with the death rate and with the indices of prosperity. The nutrition of wage-earners would naturally be better during depressions when their wages, although lower in absolute figures, have greater purchasing power, in terms of food, than during business prosperity, when wages, although inflated, are less than their previous equivalent in food value. How the unemployed and their families are fed is a subject of wide ramifications, in which previous savings, relatives and neighbors, private charities, and governmental agencies all play a part.

MISINTERPRETED FINDINGS

Attempts to show that the unemployed and their families, or any other part of the population, have really suffered poorer health during the depression have been uniformly unsuccessful. In those families who have recently become poor there may be more sickness, or more increase in sickness, than in those who have been on the relief rolls before the depression began,⁹ but this does not mean that the failing finances led to sickness, but rather that some intercurrent illness in the family led many to apply for aid who would, if in good health, have weathered the financial storms unaided. Sickness is always an important cause of poverty, in good times and in bad. Reports of undernutrition in children during depression years usually emanate from sources where no objective records are available of the amount of undernutrition existing in similar groups during years of prosperity, and numerous controlled studies have shown that the health of school children during the depression was better, rather than worse, than in previous prosperous years.¹⁰

CONCLUSION

In view of these facts, there seems to be no good reason why social workers and writers who should be in a position to ascertain the real facts, should continue to growl a direful undertone of morbid prediction and dire forebodings to deepen the gloom of a populace already distressed by severe economic and social disasters. This does not mean that funds and efforts on behalf of public health and social service may with impunity be lessened or withheld. As prosperity returns, and prices are again raised out of proportion to the purchasing power of the masses, malnutrition and disease subsequent to it may be expected, but should not be blamed on the preceding depression. It does seem, however, that plans should be so conceived that energies expended in the direction of the improved health of the population are directed, not as emergency measures, to tide us over

a temporary depression, but rather as preparation for the real dangers to health and life that lurk, not in the shadows of the depression, but in the blaze and heat of the coming economic revivals.

Olive View Sanatorium.

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DISCUSSION

A. B. COOKE, M. D. (2007 Wilshire Boulevard, Los Angeles).—Doctor Bogen's paper is a novel and striking presentation of a much misunderstood subject. It is also convincing. The popular and often voiced belief that economic depressions are always attended by increased morbidity and mortality, is clearly refuted.

Since health and longevity are considered humanity's supreme blessings, a logical corollary might be that depressions are far from unmixed evils. Such a pronouncement would probably not be enthusiastically received by any considerable proportion of the general public; but it certainly has its points.

War and pestilence, too, as factors in preventing overpopulation might be defended. Modern civilization has become so complex that no one is able to comprehend it in its entirety, or to unravel the meaning of its many tangles.

Much of the larger scheme of things will doubtless always remain obscure. It may be that depressions and wars and epidemics do serve beneficent purposes in the long run. *Quien sabe?*

This is a universe of law and order. It is not rational to conclude that human life and human affairs alone are chaotic—that chance and destiny are synonymous terms.

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CHAUNCEY D. LEAKE, Ph. D. (University of California Medical School, San Francisco).—It is refreshing to find that some enlightened physicians are beginning to interpret the influence of economic factors on public health in a manner compatible with reasonable judgment on existing data. It is quite the fashion at present to drag a health factor into any sort of economic situation, from advertising to the "farm chermurgic." It is high time that physicians asserted themselves as competent judges in regard to the influence of economic factors on public health. Doctor Bogen deserves congratulation for the skill by which he has shown that business prosperity is by no means identical with mass prosperity, and that it is mass prosperity which really determines whether or not adequate nutritional needs are obtained by the mass of the people.

⌘

CLARENCE G. TOLAND, M. D. (1930 Wilshire Boulevard, Los Angeles).—Doctor Bogen has presented some startling and apparently paradoxical facts. The efforts of all who are thinking of the people's welfare have been di-

rected toward the prevention of cyclic depressions, and the maintenance of the periods of so-called prosperity.

Yet we have been given very good evidence to show that, physically, we are better off during depressions; therefore, our chief suffering has been mental and psychic. One need hardly cite the aptness of Goldsmith's oft-quoted lines:

"Ill fares the land, to hastening ills a prey,
Where wealth accumulates and men decay."

Doctor Bogen's facts would suggest that this is a very definite physical decay.

To us, as physicians, it should give strong reasons for resenting what Doctor Bogen so well called the "direful undertone of morbid prediction" of so many social workers. They constantly and repeatedly have referred to the suffering and ill health of the poor during the depression as a very potent reason for radically changing the status of organized medicine. We shall all be interested in their answer to this gauntlet which Doctor Bogen has so effectively hurled into the ring.

PERIDURAL ANESTHESIA*

By IDA HEISSIG, M.D.
Pasadena

DISCUSSION by Charles F. McCuskey, M.D., Los Angeles; Paul M. Wood, M.D., New York City; John G. Dunlop, M.D., Los Angeles.

THIS form of regional anesthesia, due to its simplicity of performance and the satisfactory relaxation it provides, bids well to compete with subarachnoid block in the same type and well-selected cases.

HISTORY

The injection of the epidural space was started by Cathelin about 1901, when he injected a one per cent solution of cocain into dogs and obtained good anesthesia. His attempts at caudal anesthesia in the human, however, resulted in failure for many years. The publication of his works led the French surgeons to inject the sacral nerves for the relief of pain in chronic nervous diseases, and the Germans to use anesthetic agents for surgical anesthesia. Hirsch, in 1906, describes the technique and gives the results in epidural injections. Laewen, in 1910, apparently was the first to perform surgical operations on the perineum, rectum, and female genitalia under what he called "extradural anesthesia." German and French surgeons gradually increased the use of this method, but confined their technique to the injection through the sacral hiatus. The first to conceive a different method of injecting anesthetic solutions, that is, into the epidural space of the lumbar region, was a young Spanish surgeon, Fidiel Pagès. His technique and results in abdominal anesthesia were published in 1921, in the *Spanish Review of Surgery*, without, however, receiving further notice. In this country caudal epidural anesthesia, used in a few clinics for genito-urinary, gynecologic and rectal operations, preceded by many years its application to abdominal surgery. Edw. Brenner, in 1924, laments the slow adoption of this method by our surgeons, and attributes the hesitation to confusion with spinal anesthesia and its hazards.

* Read before the Anesthesiology Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25 to 28, 1936.

Neely, in 1927, presents his results in epidural anesthesia for operations, having obtained anesthesia by the injection of the caudal canal, and gaining his level —?— by the use of large quantities of solution and the Trendelenburg position. It remained for A. M. Dogliotti, Italian surgeon, to bring epidural anesthesia to the front. It is assumed that he did not know of Pages' work, as no mention is made of the Spaniard in any of his writings, though the methods are similar. Since his first report of a series of cases in 1931, his segmental block anesthesia has become routine in certain clinics in Germany and South America. Alberto Gutierrez of Buenos Aires and A. L. Soresi of this country both noted, in 1932, the disappearance of fluid from the end of the spinal needle, due to the negative pressure within the epidural space, and made use of this fact in their technique, which was further developed by C. B. Odom of New Orleans.

DEFINITION

Peridural anesthesia is the injection of an anesthetic solution into the space immediately outside and adjacent to the dura mater of the spinal cord. The results are a complete and relatively long muscular relaxation of the body segment supplied by the group of spinal nerves bathed by the solution. The number of spinal and sympathetic nerves blocked will depend upon the site of injection, and the amount of anesthetic solution used.

ANATOMY

In order to understand this type of regional anesthesia, let us review briefly the anatomy involved. The peridural or epidural space is more or less potential and surrounds the dura on all sides within the spinal canal. It varies in size among individuals with the general bony structure, and within the body with the natural anatomical swellings of the spinal cord. From the foramen magnum to the seventh cervical vertebra the peridural space is only potential, then it gradually decreases till a depth of three-fourths centimeter is reached between the fourth and eighth dorsal vertebrae, when it again narrows due to the lumbar enlargement of the cord. In the sacral region the peridural space surrounds the dural sac on all sides and reaches its greatest dimensions. The space, therefore, is deepest where the spinal cord and its roots are smallest, that is, in the upper dorsal and lower lumbar and sacral region. It extends the full length of the spinal canal, from the foramen magnum where the dura, its medial wall, is firmly attached to the periosteum, down to the sacral hiatus, and is filled with loose areolar tissue, many blood vessels and semi-liquid fat. When lightly distended, it holds about 160 cubic centimeters of fluid, one-fifth of this being in the sacral region. Solution injected into the epidural space follows the spinal nerves laterally for many centimeters, through the intervertebral foramen to the paravertebral spaces and tissues. This has frequently been demonstrated on the cadaver, and in the living by the use of solutions opaque to x-ray.

TECHNIQUE

The patient is preferably placed in a lateral recumbent position, with his back well arched, knees and head close together, shoulders and hips in the same plane. In this position, collapse, though usually due to psychic causes at this stage, is entirely prevented, and the comfortable position aids materially in the patient's coöperativeness; if necessary or desired the patient may, however, be placed in a sitting position, though it must be remembered that the solution, due to gravity, will spread mainly caudad. The anesthetic solution will flow both toward the head and the sacrum if the patient is in a horizontal position, and its flow during and after an injection will be little affected by the anatomical curvatures of the spinal column. It is advisable to have the patient lying on the same side as the incision to be made, allowing a longer contact of the nerve trunks with the anesthetic solution.

The skin is prepared with ether and tincture of iodine or whatever antiseptic is generally used, and the patient is draped as for a spinal puncture. A skin wheal is made with novocain in the center of the proper interspace. A midline puncture is best, as no blood vessels will be encountered and the posterior triangular peridural space is entered through its apex. A short, beveled spinal needle, gauge No. 20, is introduced at right angles to the plane of the back through the supra and interspinous ligaments. This spinal needle has a saline-filled glass connecting tube (as used to connect rubber tubing for intravenous infusions) attached to its hub, and is gently advanced until it pierces the ligamentum subflavum. A distinct snap is felt, and the fluid within the glass tube can be seen to move inwardly as much as one centimeter, due to the negative pressure within the epidural space. This is the positive sign to stop the advancement of the needle, and that its tip is in the proper place. Should the space be only potential in the individual, or the dura be accidentally punctured by too much force exerted on the needle, the fluid within the glass tube will be pushed outwardly by the flow of spinal fluid. The same will also happen should a blood vessel have been punctured. In either case the needle must be withdrawn a millimeter or so until the flow stops, then the procedure may be continued, or a new puncture made in another interspace. The needle is held steady with the left hand after its tip has entered the epidural space, while the glass adapter is carefully replaced by a 10 cubic centimeter Luer filled with anesthetic solution which is slowly injected. It will be noted that the solution enters the epidural space and without the slightest resistance. Five minutes are allowed to elapse before any further injection is made of the remaining anesthetic agent. This interval of time is necessary to make certain there is no intradural anesthesia as manifested by motor paralysis of the lower extremities, or sensitivity to novocain shown by collapse symptoms. If either occurs, the administration is, of course, discontinued. In the case of the former the operation can proceed under spinal anesthesia, the dose, 10 cubic centimeters, being well within same limits,

while the latter is avoided by first aspirating, thus preventing the intravenous injection.

Gutierrez and Odom usually select the second lumbar interspace for the puncture, using 35 to 50 cubic centimeters of 2 per cent freshly prepared novocain or pantocain solution, with or without adrenalin. The height of anesthesia is obtained by the amount of solution used and the position of the patient immediately after injection. Thus, 35 cubic centimeters of novocain is sufficient with slight Fowler position for lower extremities and lower abdominal surgery; 50 cubic centimeters and Trendelenburg position for upper abdominal and chest work. Odom now prefers to omit adrenalin from his solutions, as he found a number of patients showing sensitivity to this drug. His anesthetics last one hour with novocain solution alone; one and one-half hours to two hours with novocain plus pantocain. It is best to allow the patient to wait fifteen to twenty minutes after completion of the injection, either turned on his back with head raised or lowered to increase the spread of the solution over the desired area, or turned on his side, thereby increasing the intensity of the anesthesia for unilateral operation. This period of waiting is absolutely essential for the diffusion of the anesthetic solution, and the penetration of nerve sheaths and trunks.

Dogliotti, on the other hand, attaches a syringe filled with saline to the spinal needle and produces a steady pressure on the plunger with his thumb while the needle is advancing. Great resistance is felt while going through the spinal ligaments, and the sudden release of this resistance (allowing the free injection of the saline) is used as the indication that the epidural space has been reached. He varies the site of injection and the amount of solution used with the operation to be performed. His injections are made in the following interspaces:

Lower limbs, pelvis and its contents or	
inguinal region.....	L. 3 or 4 plus caudal
Abdomen, below the umbilicus.....	L. 1 or 2
Upper abdomen.....	D. 8—L. 1
Thorax and upper limbs.....	D. 4—10
Neck	C. 4—5

Solutions including 15 to 25 minims epinephrin per patient are:

Novocain		Nupercain	
Per Cent	Cubic Centimeters	Per Cent	Cubic Centimeters
1.00.....	80-100	0.10.....	80
1.50.....	45-60	0.15.....	45
2.00.....	30-35	0.20.....	30

The injections of the cervical regions are done with extreme care and gentleness, and small amounts of the solutions are used. He has performed all types of operations, with the exception of face and skull, under peridural anesthesia, and is now concentrating his peridural anesthesia work for the upper extremities and neck. He prefers four or five separate doses of 10 cubic centimeters each, letting a short time elapse between each injection, to obtain more localized intense anesthesia, and uses larger quantities of solution or the

more potent nupercain for extensive and bilateral surgery.

It is not to be forgotten that adequate premedication in doses suited to each individual patient is essential for the success of any anesthesia and especially local or regional nerve block. The preceding night a sedative is given to assure the patient proper rest. The following morning, to prevent toxic reactions of novocain and epinephrin, a barbiturate is administered one hour before; morphin and hyoscin one-half hour before surgery to relieve the psychic strain. This will produce a drowsy, but coöperative patient.

COMMENT

The patient while on the table requires certain attentions and needs to be carefully watched. His body should be made as comfortable as possible with pillows or by flexion of the extremities, and this can be done without interfering with the surgical exposure necessary. Discomfort of the patient under any local anesthesia is frequently due to this cause rather than inadequate nerve-blocking. Nausea occurring in a small group of patients can be treated by inhalations of oxygen-carbon dioxid, but many will go to sleep and remain so throughout the operation. Pulse and respiration will be found unaffected. The blood pressure will, in some individuals, fall 20 to 30 millimeters, being due to the anesthetization of the sympathetics, and the amount of the drop will depend on the extent of the anesthetized area and the number of sympathetics involved. This blood pressure drop requires no treatment, and will correct itself as soon as the anesthetic wears off.

A certain number of patients will always be found who are emotionally unstable and who misinterpret their sensations of touch and pressure, insisting they are having pain. A light gas anesthesia to produce unconsciousness will be found sufficient, as the relaxation due to the peridural is adequate for the surgery. On the other hand, severe trauma to the peritoneum by retractors in a small incision, and rough pulling on the viscera, will be resented by the patient as in any other type of local block. The surgeon must coöperate by gentleness in handling of the human tissues so often forgotten when the patient is deeply under an inhalation anesthetic.

Gutierrez, in his series of three thousand cases, reports failure in less than one per cent, and two fatalities for which he does not hold the anesthetic responsible, but attributes them to advanced age and severe myocardial damage. Odom has 6 per cent of incomplete anesthetics and one severe reaction due to hypersensitiveness to novocain or adrenalin, but no deaths in three hundred cases. Dogliotti, who had one serious reaction in three hundred cases, supplements 10 per cent of his cases with light gas anesthesia. Hess, following Dogliotti's technique, finds 50 per cent of his patients complaining of pain during the operation, with one per cent complete failures. This writer's percentages of complaints are out of proportion to all others, and undoubtedly due to lack of, or

insufficient premedication, as their use is not mentioned in his work. Gutierrez, above all others, has shown that difficulties and failures can be eliminated through greater experience with this method.

ADVANTAGES AND DISADVANTAGES

Peridural anesthesia has all of the disadvantages of any local or regional block, which are:

Greater time consumed in administration.
Unsuitable for excitable patients.

Idiosyncrasies to drugs used which are rare.

These disadvantages are far outweighed by the many and definite advantages, which are:

From the standpoint of the surgeon:

Muscles are well relaxed.

Abdomen is quiet, because there are no exaggerated movements of the diaphragm to push out the intestines.

Intestines are collapsed as in spinal.

No interruption of the surgery by vomiting of the patient.

No postoperative sequelae of any kind.

From the standpoint of the patient:

No discomforts due to the anesthetic, as nausea and vomiting, cough, and possible bronchial pneumonia.

No inability to void, no headache or backache.

No inability to move extremities.

In general:

No interference with respiration, though the chest wall is anesthetized.

Collapse is greatly reduced in frequency and severity.

There are no toxic effects on any viscera.

No possibilities of meningeal irritation.

No possibility of the anesthetic solution diffusing to the bulbar and cerebral centers.

No sphincter paralysis.

IN CONCLUSION

Peridural anesthesia is particularly suited for the aged, debilitated, anemic, and patients with hypo- or hypertensions, myocardial and renal impairment, as well as those with upper respiratory infections. It has been successfully used for all types of operations below the chin in over five thousand cases. The technique, as practiced by Gutierrez and Odom, using the visible negative pressure sign and the second lumbar interspace for the injection of the anesthetic solution, is unquestionably the most simple, safe, and certain in obtaining satisfactory anesthetic results, and can easily be acquired by any anesthetist interested in regional anesthesia.

415 Anita Drive.

DISCUSSION

CHARLES F. MCCUSKEY, M. D. (3435 Amesbury Road, Los Angeles).—The chief indication for using peridural anesthesia for lower abdominal work is the freedom from postanesthetic sequelae, which we occasionally see following the use of spinal anesthesia. It must be kept in mind that it requires a very slight error in technique to change a

peridural anesthetic to a spinal anesthetic. For this reason the importance of developing a careful technique during the injection cannot be overemphasized. For the first one hundred cases injected by any individual, I think it would increase the factor of safety if the patients upon whom it is used were limited to those that we would consider good risks for spinal anesthesia.

I would like to congratulate Doctor Heissig on the excellent presentation of this subject, and urge her to continue the use of peridural anesthesia until several of her staff have become proficient with this form of injection.

✽

PAUL M. WOOD, M.D. (131 Riverside Drive, New York City).—Doctor Heissig has very thoroughly reviewed the available literature on peridural anesthesia, and I agree with the findings concerning the relative safety of this regional form. In cases where the dura has been penetrated, I have personally observed patients who apparently did not have true spinal anesthesia as suggested by Doctor Heissig and others of withdrawing the needle slightly.

However, I have also observed two cases where peridural anesthesia was attempted, and where there was no question but that some spinal anesthesia was induced, possibly by leakage into the subarachnoid space from sudden injection pressure into the peridural space.

The greatest disadvantage in my practice is the length of time required for securing this form of anesthesia. A technical maneuver, which has aided me, is the use of a three-way stopcock between the needle and syringe. The No. 10 or No. 20 syringe is filled with the fluid to be injected. A glass "filter adapter" (No. 21 Becton Dickinson), which holds a little less than one-half cubic centimeter of fluid, is placed in the upright position. The stopcock is adjusted so that the fluid to be injected into the peridural space is forced into the glass adapter. The stopcock is then set, and with the entire apparatus balanced in the hand the needle is advanced through the tissues and ligaments. The moment the peridural space is entered, the fluid quickly disappears from the little glass adapter. Without any further manipulation the lever is set in such a position that the fluid in the syringe may be immediately injected. This has tended to eliminate puncturing of the dura during the manipulation of attaching the syringe.

I am convinced that this form of anesthesia has a definite place in the armamentarium of professional anesthesia, and provides efficient and relatively safe anesthesia in selected cases.

✽

JOHN G. DUNLOP, M.D. (111 North Normandie Avenue, Los Angeles).—The value of peridural anesthesia and its ultimate place in the repertoire of the anesthetist is yet to be determined. The administration is more difficult, and requires a greater exactness than for a spinal anesthesia; and as yet few anesthetists in America have had sufficient experience with the method to warrant a just evaluation of its merits. In certain clinics in Europe and South America it has apparently proved satisfactory, and those persons in this country who are in a position to do so should be encouraged to perfect the technique and determine for themselves its value.

Except for patients evidently suffering from hyperthyroidism, adrenalin, I think, should not be omitted from the anesthetic solution. By decreasing the rate of absorption, it decreases the toxicity, and also prolongs the anesthesia. Because an occasional patient is apparently hypersensitive to the drug, however it is probably wise to limit the amount used. For years, in our sacral anesthetics, which are really low peridural anesthetics, we have been adding 6 minims of 1-1000 adrenalin to 100 cubic centimeters of one per cent novocain solution, with no severe untoward reactions attributable to the adrenalin. A similar restriction would probably be wise with peridural anesthetic solutions.

Fifty cubic centimeters of 2 per cent novocain solution contain 1,000 milligrams of novocain, and this amount injected into the highly vascular peridural space is capable of producing rather acute novocain intoxication. A slow administration, plus the judicious addition of adrenalin to the anesthetic solution, is therefore indicated.

THE LURE OF MEDICAL HISTORY†

THE WHITMAN CENTENNIAL: THE LATE DR. MARCUS WHITMAN*

By H. M. F. BEHNEMAN, M.D.
San Francisco

ONE hundred years ago this month, what was probably the first American home on the Pacific Coast was established. On the banks of the Walla Walla River, in eastern Washington, Dr. Marcus Whitman and his wife, Narcissa Prentiss Whitman, ended their long wedding journey and began housekeeping in a crude log cabin. The location of their home was known by the Indians as Wailatpu, or the "Place of Rye Grass," and it was the favorite resort of the Cayuse and Walla Walla Indians.

THE CENTENNIAL MEMORIAL OF JANUARY, 1936

In commemoration of the importance of this event, a public celebration, or centennial memorial, was held last August in Walla Walla, Washington. This was a three-day succession of events depicting the life and work of these noble pioneers of the Northwest. The first day was devoted to the interests of medicine, under the direction of the American Medical Association, when in the beautiful open amphitheater on the campus of Whitman College there were inspiring exercises. A large number of the residents of that part of our Northwest country are direct descendants of those who came in covered wagons, and with that hereditary, inbred spirit of the pioneer, they opened their hearts and their homes to all who came to do honor to the famous country doctor. Each day there was a huge parade, and each night a well-trained, spirited production, by three thousand actors, depicting the Northwest territory from the arrival of Doctor Whitman to the present. The citizenry turned out en masse in the costumes of the covered-wagon days, and each of the ten thousand visitors realized before he left that the preparation of this event had for two long years been entered into with shoulders to the wheel, as it was in the westward crossing. For many months the State of Washington, through the newspapers, ran a popular contest, so that each county in Washington was represented by a direct descendant of a covered-wagon pioneer, chosen through her popularity with the people of her county.

On Medical Day, addresses were given by Dr. Frederick C. Waite, Dean of Western Reserve University Medical School; Dr. S. B. Penrose, President Emeritus of Whitman College; and by the presidents of the Washington and Oregon

†A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

*Presented before the San Francisco County Medical Society, January 12, 1937.

State Medical Societies, as well as a trustee of the American Medical Association; and the address to the laity was entitled "A Century of Progress in Medicine."

PROFESSIONAL TRAINING OF MARCUS WHITMAN

Marcus Whitman came to the Northwest as a young man, and met a tragic death a few years later, having been born in 1802 in a New York village now known as Rushville, named after Dr. Benjamin Rush. In the veins of his parents was the blood of fearless, decisive, migrating pioneers. When Doctor Whitman was eight years old, his father died and he was sent to live with his uncle in Comington, Massachusetts. When he was thirteen, he moved to Plainfield and became a pupil in the well-known private academy of Dr. Moses Hallock, from which emanated some of America's most noted men. When he was ready to enter college at eighteen, he wanted to become a clergyman; but lack of funds prevented this, so for a period of five years he worked in the tannery and shoe shop of his stepfather and in the sawmills of his uncle. At that period, entrance to the ministry demanded four years of college education and three years in a school of theology. The study of medicine, however, could be begun in one's own home town, under the local doctor, and from then on pursued jointly with other duties.

FAIRFIELD MEDICAL SCHOOL

Fortunately for Marcus Whitman, the town's only physician, Dr. Ira Bryant, was a skillful doctor and a man of high integrity, and in 1825, with two years of study under Doctor Bryant behind him, Whitman was ready to enter the study of medicine, there being at that time eight medical schools in New England, three in New York State, and only four more in all of the United States. Whitman entered in October as a student in the Fairfield Medical School, known also as the College of Physicians and Surgeons of the Western District of New York. The school then had five professors, one hundred and thirty students, and one hundred trustees!

This medical college, however, had one distinction. It was the only school in America where human dissection could be carried on legally. The cost of this medical education is very interesting. The session lasted four months, from October 1 to February 1. At that time the students paid each individual professor; he "bought tickets" of them. In this year of 1825, the five tickets cost \$54; the dormitory room cost 30 cents a week; board was \$1 a week; and firewood cost \$1.25 for the entire session. In addition, there was expense for books, candles, and laundry, so that the total cost for the entire session was about \$100. That may seem small to us now, but it took Marcus Whitman two years to save it. After just one session at this school, Whitman was admitted to his County Medical Society upon examination and received his diploma on May 9, 1826.

After practicing for a while in New York State and Pennsylvania, he moved to Canada; but being of an ambitious and searching nature, he wanted further formal education. Accordingly he reentered Fairfield Medical School in 1831. His new teacher of surgery was John Delamater, who in forty years of teaching held nine professorships in as many different schools, and who, with Oliver Wendell Holmes, reestablished the decadent Dartmouth Medical School and took part in founding the Cleveland Medical College, now the Western Reserve University School of Medicine. So on January 29, 1832, Marcus Whitman received the M. D. degree, a thoroughly educated physician for his time, and soon after, as a country doctor, began a residence of three years in Steuben County, New York. There was no other doctor within a radius of sixteen miles, so he had a varied experience.

MEDICAL PRACTICE ONE HUNDRED YEARS AGO: FEES RECEIVED

There were then no specialists, no consultations, no office hours, and the young physician responded to calls regardless of weather, location, or time of day. The only transportation was on horseback, and the busy doctor needed more than one such transport. In fact, a doctor's success was sometimes measured by the number of horses he maintained, and a new force was given to the old expression, "one-horse," a deprecating term long applied in various ways. Naturally, he had to furnish medicines to his patients, crude drugs ground by himself, as there were no apothecaries. All surgery was done in sick folks' homes; and as there was to be no anesthesia for another fourteen years, speed was the index of surgical skill: a good surgeon amputated an arm in three minutes and a leg in six! There was no antisepsis; and instruments once used were wiped off and ready for the next victim. It was to be fifty years before bacteria were discovered. The doctor's fees were of interest: a house visit within three miles was 25 cents, and for each mile thereafter an additional $6\frac{1}{4}$ cents was allowed. If the same patient had a second call the same day, it was half the fee of the first one! Thus the doctor could not be accused of running up a bill. Medicines were extra and averaged $6\frac{1}{4}$ cents each. The office call netted the doctor $12\frac{1}{2}$ cents. The surgeon, too, was not on the road to wealth: Twelve and one-half cents was charged for tooth extraction; fractures were rated from \$2 to \$5, and a charge of \$5 was made for lower-arm amputations, and \$20 for the upper leg. Obstetrical deliveries were from \$1.50 to \$3, dependent upon the duration of labor.

The doctor in those days never spoke of his "income"—it was what he "put on the books": a very successful country doctor averaged from \$75 to \$150 per month. His cash income was very little; he received a great deal in merchandise, and more in services of various kinds. (I have some account books to show you later where even the bar claimed \$12 used credit.)

CHOLERA EPIDEMIC OF 1832

The year 1832 was a period of tortuous practice for the American doctor, more than any year in the country's history. The terrifying cholera spread over the Erie Canal and up the Mississippi like a prairie fire. In this epidemic Whitman saw and learned much.

WHITMAN'S MISSIONARY EXPLORATION

And then came into his daily routine an event which changed not only his life, but the lives of countless to come, as well as the geography of the United States. Whitman, in his heart, never lost the desire he had cherished to become a minister. Out of a clear sky in 1835, the famous clergyman, Rev. Samuel Parker, persuaded him to be his companion in a missionary exploration to the Northwest. Here Whitman saw his opportunity to combine the two greatest fields of service to humanity, the ministry and medicine.

So, in March, 1835, he bade farewell to the sad people of his district, for he was not just their doctor; he was their friend and counselor. Picking his best horse, with eyes toward the unknown western wilderness, he started alone for St. Louis, seven hundred miles away, which he reached early in April. There the Rev. Parker met him, and from there they went by boat on the Missouri River to Liberty, Missouri, the starting point of many caravans to the West and Southwest. And so, in the middle of May, these two brave hearts with sixty men, comprising the caravan of the American Fur Company, pushed westward. I need not comment upon the ruggedness of these sixty travelers. Unfortunately, the Rev. Mr. Parker was a bit inconvenienced by the hardships of travel and was poor at concealing it. He soon became an object of contempt and the target of rotten eggs. Moreover, the whole outfit felt like birds of a color traveling together, and thus Whitman was as mistakenly labeled as Parker. This animosity grew until there was much talk of murdering the pair. Fortune, however, decreed otherwise and saved them in the form of dreaded cholera. Where the Platte River joins the Missouri, one of the caravans succumbed to the disease. They were two hundred miles from any town; they had three choices—desertion, death, or the despised doctor.

Fontanelle, the brave caravan leader, sent for Whitman and reported three cases of cholera. Must they turn back? Must they all die? Then they learned to know Marcus Whitman. He had seen cholera; he had the drugs with him that would stop early cases; so, as a result, only three members of the caravan died. Overnight the doctor was the leader among men; his place was so high that his friend the minister basked safely in Whitman's shadow, ignored and harmless.

So the eleven-day stop ended, and the caravan headed once again into the wilderness of the land of the setting sun. For fifty fatiguing days under the burning rays of summer sun, they plodded on, across eight hundred miles of roadless, treeless plain and prairie. The only unscheduled daytime

stops were those to kill an animal to furnish fat with which to grease the creaking, whining wheels. The wagons were abandoned at Fort Laramie, now Wyoming, and their contents transferred to the backs of pack animals. From then on, as the strength of a chain in its weakest link, the speed of the caravan was the pace of the slowest man or animal.

ON THE CONTINENTAL DIVIDE

But after many narrow escapes from Battles with roving Indians, the caravan reached the summit of the Continental Divide, and on August 10, 1835, Marcus Whitman gazed westward, the first graduate of an American medical school to stand on the western side of the Rockies, the pioneer of all the thousands of us who have administered to the millions residing in this great empire in the past century.

Two days later another historic event took place. The caravan came to the crossing of the Green River, where about two thousand Indians and two hundred white trappers were gathered. Among them was James Bridger, noted American guide and scout. He was suffering and annoyed at the presence of a large iron arrowhead he had carried for over three years just under one scapula. Whitman removed it for him and also one from another trapper. Can you for a moment visualize the historic setting—was there ever any amphitheater containing over two thousand Indians and whites wherein one physician's future standing with his fellow man was more at stake? The gratitude of the two men was unlimited, and the astonishment of the Indians beyond our comprehension. Thus resulted a lasting friendship with Jim Bridger and a firm reputation as a surgeon in the entire Northwest empire. The Indian chiefs sent runners clear to the Columbia River to tell of the coming of the great white medicine man.

THE MISSIONARY PROJECT

And now another important episode took place. After a long conference it was decided that the Reverend Parker should continue West and Whitman should turn back and go East for more missionaries. It took him until November to reach St. Louis, and in the opposite direction Parker had reached the Columbia River in August. Whitman had great difficulty in finding recruits, but in February, 1836, he persuaded the Rev. Henry H. Spalding to join with him. Before starting, however, he made the trip back East to claim Narcissa Prentiss as his bride—a lovely, cultured, educated young woman, courageous beyond words, zealous to carry the word of God to the Indians, and deeply in love with Marcus Whitman.

So the Whitmans and Spaldings joined the caravan of 1836. These two women were the first white women to cross the Rocky Mountains, and the party arrived in the Columbia River valley late in September. There Dr. and Mrs. Whitman established a station on the banks of the Walla Walla River, while the Spaldings went one hundred and twenty miles farther on to the Snake River valley, now in Idaho.

THE POST AT FORT WALLA WALLA,
WASHINGTON

Here at Fort Walla Walla, which became a very important post, Whitman and his good wife fulfilled all the strenuous duties of missionary, doctor, agriculturist, and historian, for eleven years. Their lives were of hardship, particularly for a gentlewoman of the sheltered eastern home life she had known; but she was equal to it. While Whitman performed his medicine and surgery, teaching of agriculture and many other pursuits, Mrs. Whitman taught the Indian women to cook, to sew, and to speak our language; before long she had a large school of Indian women and children, eager to learn the things she had to teach them. Both of the Whitmans worked arduously to convert the Indians to the white man's religion.

In 1838 the second missionary party arrived, containing nine white people, including the Rev. Cushing Eells. The mission and trading post grew far beyond their expectations. Meanwhile great happiness had come for the Whitmans in the form of a baby daughter, born March 14, 1837, perhaps the first white child born west of the Rockies. Blonde like her mother, she was worshiped by the Indians.

We come near the end of the tale now, and fortune appears to desert the Whitmans, finally giving place to bloodshed and tragedy. The first blow to the faithful pair came late in 1839. With her father busy in the fields and her mother teaching school, the little two and one-half year old child wandered alone to the forbidden banks of the Walla Walla River and tumbled in. Her body was found by the heartbroken Indians and returned to the grief-stricken parents. The shadow of trouble grew larger. In a few months, Whitman heard the mission board in the East was about to abandon this mission. Also, now at its height was public discussion as to whether the United States or Great Britain should buy Oregon Territory. It was then under the administration of both countries.

WHITMAN'S CONFERENCE WITH PRESIDENT
TYLER

So, once again, early in 1842, Whitman made the long trek to the East. There, through his eloquence and sincerity of purpose, he convinced the Board the mission should remain. Achieving this, he then went to Washington. A leader among men with the blood of migrators coursing in his veins, he appeared before President Tyler and part of his cabinet in an historic session. He urged Secretary of State Daniel Webster, members of Congress, and the President, to purchase, without further hesitation, this Northwest empire. They listened and were impressed with his tales of wealth in very useful land, with a large river running to the Pacific Ocean—the mighty Columbia. As we know, Congress did not hesitate very long.

OREGON TERRITORY

The rest of that year Whitman spent in zealous enlistment of settlers for the new land, and in

1843 he led to Oregon the first of never-ending caravans, a body of eight hundred people. By 1847 the whites in the new Oregon Territory had increased to over three thousand. His mission was surrounded by settlers and the ever-present Cayuse and Walla Walla Indians. But, unknowingly, the end was near. Distrust and unrest among the Indian tribes increased with the tide of white settlers in the middle forties. The Indians referred to Whitman as the good doctor and regarded Mrs. Whitman as an angel of mercy, but felt more and more terrified at the thought of being driven from the home of their fathers. One Indian was the leader in this movement, by name of Tam-a-has, and his wily associate, Joe Lewis, kept firing the furnace of hatred. They told their tribes Whitman was the man who brought the whites to steal their land. Then, at a crucial moment Fate was most unkind, for the first epidemic of measles broke out at the mission and spread rapidly among the Indians and whites. Naturally, Whitman was unable to control it, although he worked day and night to save those he could. The many deaths left but one path to follow in the mind of the Indian—revenge upon the medicine man.

THE MASSACRE

The befriended reds soon reverted to the centuries of barbarism in their veins. On a cold November night in 1847, there was a knock on the mission door. Whitman was weak from fatigue and worry, and asleep. Narcissa Whitman opened the shutter; two familiar faces, Lewis and Tam-a-has, dourly looked at her, demanding to see the doctor for medicine for their squaws. With fear in her heart she locked the door and called her husband. He, too, was suspicious of trouble, but did not feel it was so close at hand. She begged him not to see them, but he pointed out they were far outnumbered and it would be better to be friendly, saying: "God's will shall soon be known."

He arose and locked the door behind him into the inner part of the house, went to the outer entrance and welcomed the two Indians. They demanded medicine for their squaws and that was all. Whitman talked a few moments to them, relieved that they did not want him to go to their tents. The two pairs of treacherous eyes followed him. As the young martyr bent over his bag, the swift, sure stroke of a tomahawk deep into his skull ended a noble life.

Pandemonium broke loose as the house was being surrounded while the two Indians were talking to Whitman. A shot through the open window brought down Mrs. Whitman with a bullet under her arm and in her cheek; she lived for some hours. One by one, fourteen white lives were taken during the remainder of the night. Fifty loyal Indians and whites were wounded in an effort to stop the massacre. All the remaining whites were held hostages for a month, and then sold at a high price to Governor Ogden in Umatilla. Thus ended Waiilatpu Mission, but thus began monuments to its memory.

WHITMAN COLLEGE

Indian wars continued for twelve years, and then in 1859 the Rev. Cushing Eells returned to the scene of the massacre. He resolved to devote the rest of his life to honoring Dr. and Mrs. Whitman, and the monument he erected was Whitman College, for seventy-five years a worthy tribute to the Whitman's, a coeducational college of high character and large enrollment, in Walla Walla, Washington.

In the pictures frequently shown, you may see the grave of Marcus Whitman, a marble shaft pointing high into the sky, arising on a peaceful hillside in the rolling green hills of eastern Washington. There are tablets to his memory in the three places where he practiced in New York, and the State of Washington has a county named after him.

IN CONCLUSION

All these commemorate a capable physician, a true pioneer, a fearless American of sterling integrity. But, as I look back and realize the multitude of grateful people who came from four states to honor Whitman on medical day, it appears to be more than just a tribute to Whitman. It was also a tribute to the ideals of American medicine, for they gathered to hear all about what we are doing and hope to do in the practice of medicine. In the amphitheater in the shadow of the Whitman Memorial Building, it was heartening to know that these people left the routine of busy lives, some of them for a week, to travel many miles to honor and revere a noble character in American medicine. It brought to mind words spoken two thousand years ago by Cicero: "Memory is the treasury . . . of all things. The life of the dead is placed in the memory of the living."

334 Post Street.

CLINICAL NOTES AND CASE REPORTS

AN EFFICIENT BACK BRACE

By HUBERT R. ARNOLD, M.D.
San Francisco

NCESSITY frequently compels one to devise ways and means which would not otherwise materialize.

Several years ago I was unfortunate enough to develop a destructive lesion of my fifth dorsal vertebra, with extension into the fourth and sixth vertebral bodies. After a prolonged period of bed rest, x-ray and other appropriate therapy, I became ambulatory and was confronted with the problem of immobilizing my upper dorsal spine. Since my general health was otherwise excellent, I was, naturally, anxious to be fitted with an appliance which would give the proper degree of fixation, but at the same time afford sufficient freedom of motion so I could get back to practice. The Taylor brace soon proved awkward and in-



Fig. 1.—Front view of brace not in use.

efficient, as it was apparent through one's clothes. The perineal straps were uncomfortable. It did not give proper support, and one had the general feeling of being the support instead of being supported. If you have never worn one of these contrivances you will not appreciate what I am saying; besides, there is a multiplicity of straps and buckles, and the breast straps are worthless. It is uncomfortable, particularly when one is sitting down, and in spite of the perineal straps, it hikes upward in this position.

Then I was fitted with a crutch brace. The lower part of this brace was made identical to the brace which I have devised and shall describe in detail below. The crutch was a constant annoyance and discomfort under the arms and, besides, the brace did not give the proper support to my upper back. I was in constant fear, also, of a crutch paralysis from the pressure in the axillae. This brace, indeed, did not give the proper freedom of the arms, and it was impossible to let one's arms hang down by the sides of the body; the arms were always out at an angle and the shoulders somewhat pushed up. A friend remarked to me one day that I looked tough. After a busy day I frequently felt that I was.

A light plaster jacket would give good support, but this is not practical for permanent wear and, besides, it would not give the desired freedom for one who is actively engaged in work.



Fig. 2.—Front view of brace in use.



Fig. 3.—Side view of brace in use.



Fig. 4.—Back view of brace in use.

I presume there have been numerous other back braces and devices for back support, but in general, from what I have seen of such appliances, they are no commentary to the mechanical ingenuity of the orthopedic surgeons, being mostly inefficient, awkward, and uncomfortable for the patient.

The chief difficulty with all back braces is this: They hang on one's back and depend for support on the straps fastened here and there to pull the thorax backward. The principle of the brace I have designed is to support the back by pressure on the upper anterior chest, just below the clavicles. When the lower part of the spinal column is encased in a pelvic girdle (to be described below) at the level of the sacrum, and the lumbar and dorsal spines lie flat against the two upright steel supports (one on either side of the spine), and the upper thorax is partially encircled by a spring band which snugly fits the body and clears the axillae and ends anteriorly in a circular enlargement (padded) just beneath the clavicles, then flexion of the spine is impossible. The entire dorsal spine is supported by pressure anteriorly below the clavicles. Side motion is prevented by a steel upright on each side.

The construction of this brace is simple. A pelvic girdle is made of plaster. While the plaster is still wet it is cut off and immediately reshaped. A model is made from this. Then a steel band (formed of sheet steel) is made to fit the model. This band is about one and a half inches wide and of proper thickness. Anteriorly it is curved somewhat upward. This encircles the pelvis just below the iliac crests, and sufficient space is left anteriorly to enable one to put it on with ease. Then the two spinal uprights are riveted to this base. Their length depends on the patient to be fitted. The side uprights are then put in place, reaching within about two inches of the axillae. The top band is made of duralumin and the ends are flanged out and perforated so a pad can be sewed on. These padded ends press on the chest just

below the clavicles. Sufficient clearance must be left under the axillae. It is neither necessary nor desirable to pad this band, except the ends where they press under the clavicles. A pattern is cut out of paper, and this duralumin band is fashioned from this. It is then riveted to the four uprights.

The four uprights are covered with a soft leather, and a pelvic girdle is made with heavy but pliable leather. It is a good plan to perforate this girdle for ventilation. Just two straps are necessary to hold this brace in place. These buckle across the lower abdomen.

Reference to the photographs will show at a glance the construction of this brace and how it looks when worn. I am the model in this instance. A front, back, and side view are shown, and one photograph is the brace not in use.

This brace is simple in construction, light, gives satisfactory immobilization of the back, reasonably inexpensive, and quite comfortable to wear.*

450 Sutter Street.

* This brace was worked out in the 1117 Market Street shop of C. H. Hittenberger Company, San Francisco.

I am indebted to Mr. Hittenberger personally for the unselfish giving of his time and material, as well as for many helpful suggestions.—H. R. A.

We should endeavor to get ideas from those who conceived or created them, thus bringing directly to bear upon our lives their wisdom and conceptions of beauty. Not content with the distorted impressions of second-hand report, we should let creative men speak directly to us. How can this be done? By coming to know their lives and their works—the books they wrote, the truths they established, the principles of ordered society they laid down, the songs they composed, the pictures and statues they made, and the cathedrals they built. They quicken us to our best; they are the great teachers of the race.

What you know and can do differs from what you used to know and do. No man's skill remains the same year after year. You gain and lose. You are probably now better able than formerly to earn your living—provided you can get a job—but, one may guess, less fresh in algebra. From past training and experience you carry along what you review, use, are interested in.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

CONSTIPATION IN CHILDREN

I. ETIOLOGY

E. EARL MOODY, M. D. (3780 Wilshire Boulevard, Los Angeles).—Constipation has been defined as that condition in which food taken eight hours after defecation is not passed in forty hours. This may be caused by certain conditions in which the passage of the feces through some part of the colon is delayed, though the act of defecation may be normal. Deficient motor activity of the colon, diminished reflex activity and inhibition may be registered as contributing to this type of constipation. Again, the fecal matter may pass properly through the colon, but the final evacuation may be inadequately performed. Laziness, fear of pain due to such condition as anal fissure and hemorrhoids, and failure to obey the impulse of defecation are illustrations.

The medical training of the profession and of the laity has been such that we are led to believe that there should be a daily evacuation of the bowel. This idea has done much to make the human race "defecation conscious." This consciousness perhaps has done much to contribute to the causes of constipation, because interference with normal processes too frequently results, in order to insure daily evacuation. Perhaps this idea has played too much importance in the treatment of disease. With a daily bowel movement in illness, we see some tangible result of our treatment which assures us that we are making certain of at least one life process, even though this is brought about by the use of drastic irritants. Perhaps it is not medical heresy to allow the acutely ill patient, sick with pneumonia or other severe infection, to go several days during the acute stage without a bowel movement. If this is heresy, certainly no one can deny that the energy and strength expended in the daily struggle with the bedpan and the effects of purging would be conserved to fight the disease.

The Newly Born.—If we modify the above definition of constipation somewhat, we can readily see that the newly born might present such malformations that would make bowel movements impossible. An atresia can occur anywhere along the gastro-intestinal tract. Those of us who see many newborn are astounded at the relative frequency of such malformations. These are seen most frequently in the esophagus, the anus, rectum, and, less frequently, in other parts of the intestinal tract. If sufficient amount of meconium is not passed, or its absence is noted, or the stools fail to go through the transitional stage to the milk stool, investigation will probably reveal some such malformation.

Some newly born infants may be so weak that they do not possess the muscular power to bring about sufficient peristalsis and the proper emptying of the lower bowel. This is most often seen in small prematures and other congenitally weak infants.

While we are discussing this problem in the newborn, let us mention, in passing, the nefarious practice that some physicians still follow of prescribing castor oil routinely for all newborn. This practice has no anatomic, physiologic, or pharmacologic basis. It cannot be condemned too strongly. It belongs in the dark age of medicine. This is the entering wedge to the cathartic cause of constipation.

Other Abnormal Causes.—There are certain diseases or abnormal conditions which can cause constipation. Pyloric stenosis, severe pylorospasm, intussusception, and other types of intestinal obstruction which prevent the normal passage of the intestinal contents naturally prevent fecal evacuation or reduce the amount. The constipation associated with appendicitis, peritonitis, pneumonia, and other severe infections need only be mentioned in passing. Lead poisoning and Hirschsprung's disease, both rarely seen, cause very severe and obstinate constipation. The general muscular atony seen in rickets, cretinism, and other constitutional conditions is associated with an atony of the intestines, and constipation usually results. Other findings in these abnormal conditions readily make the diagnosis certain, and the cause of the constipation, if present, is obvious.

The Breast-Fed Infant.—Constipation is rarely seen in the breast-fed infant. This is probably due to the presence of a relatively large amount of sugar which is easily fermented in the bowel. This produces an acid state which stimulates peristalsis. These infants may so thoroughly utilize all the food eaten that there is little residue left. A major reason for this is that in mother's milk there is a relatively small amount of protein and fat, as compared with cow's milk. It is these substances that contribute mostly to residue. It is common to see a breast-fed infant have a stool which is soft, of normal odor and color, and well-digested, only every two or three days and yet be perfectly comfortable. One is loath to call this state constipation. If too much attention is given this condition and enemas or cathartics started, constipation then will surely be fastened upon the child. If left alone, or accessory foods added, nature will produce a normal natural habit of bowel evacuation, especially if some effort to train the child is employed. Of course, there may be present in the breast-fed infant sufficient atony in somatic and intestinal muscles that, in spite of sufficient

food, proper training, and the addition of accessory foods, constipation remains a major problem.

One of the first indications that a breast-fed infant is not getting enough to eat is to see the daily three or four normal stools formerly had, reduced not only in number, but in quantity. Naturally, this condition is the result of reduced residue. The weight gain also slows or remains at a standstill. The addition of other food, sufficient to meet the caloric needs of the child, is all that is necessary to correct the condition.

Not infrequently small infants are seen whose anal sphincter is so spastic or the opening so small that there is difficulty in the small infant developing sufficient *vis a tergo* to overcome this added impediment to bowel evacuation. An examination with the little finger, and a careful daily stretching of the sphincter, will prove and overcome this condition.

The Artificially Fed Infant.—Constipation is much more commonly seen in the artificially fed infant. This is quite natural when we consider that we are dealing with a physical and chemical composition in cow's milk quite different from that in "mother's milk." There are other factors that must be considered, for we will see two children of the same age and weight being fed the same formula, one having three or four loose stools daily, while the other has a hard, constipated stool. The difference must, of course, be attributed to anatomic, physiologic, and autonomic differences in the two children. However, the fat, protein, mineral, and carbohydrate differences are largely responsible for the usual increased evidence of constipation in the bottle-fed infant. The casein (protein), fat, and calcium content of calf's food is several times that of mother's milk, while the sugar content is less. This makes for increased bulk. The residue forms pasty, heavy stools, often composed of insoluble calcium and magnesium, fatty acid soaps, which are passed only with great difficulty. A reasonably soft residue leads to an easy evacuation. The relative insufficiency of an easily fermentable carbohydrate found so freely in mother's milk fails to bring about an acid condition of the lower intestines which favors peristalsis. Also the increased amount of protein tends to neutralize the laxative effect of the fermented carbohydrate. The reaction of the constipated stool in the artificially fed infant is usually alkaline, and this tends to inhibit peristalsis.

This natural tendency in the infant fed on cow's milk makes the introduction of habit-forming enemas and cathartics easy. A knowledge of the basic principles of artificial feeding, permitting of the proper modification of this calf's food, will in most cases correct this constipation tendency, and thus prevent the frequent use of the habit-forming enemas and cathartics.

Older Children.—In older children we see the results due to early bad or inadequate training of bowel evacuation. If proper attention is given the infant when a few months of age, much of the difficulty encountered in later childhood would be avoided. At this early period the mother should place the child on the pot after the insertion of

any inert instrument such as a catheter, thermometer, soap-pencil, or gluten suppository, at a regular time daily. The infant soon learns that whenever the pot is offered, a bowel movement is expected. This, regularly carried on into the runabout period, and the going to the toilet regularly without hurry during the school-age period, other things being equal, will prevent constipation.

The position at stool in the small child may be important enough to mention here. Too often the small child is placed on a toilet seat not fitted to his size, and ability to assume the natural position of defecation is thwarted. The correct position is the squatting one. Here the thighs are pressed on the abdomen, and the "accessory" muscles of defecation are thus brought into play. This position should be assumed as the small infant is held over the pot on the mother's lap. The small pot on the floor best serves this purpose for the older child. The average toilet seat is not comfortable nor in any way adapted to the small child. These seats and large pots too often also compress the nates together, thus increasing the force necessary to bring about the defecation.

In school-age children, the regular visit to the toilet is too often omitted, or, if followed, the child is in a hurry and does not take sufficient time because of the rush for school. The child arises so late that no time is allowed to obey the impulse which comes from regular training. This impulse is thus throttled, morning after morning, and often again through the day, because of the urge of play or stress of other activities. Thus, the rectal reflexes pass, the fecal contents accumulate in the rectum and sigmoid, which eventually become permanently relaxed and the contractility is impaired. Thus, fragmentary defecation results, much feces being left in the lower bowel to further distend and relax. When this is the usual routine, constipation becomes a fixed condition because of the permanent damage done to the tone and reflex action of the bowel.

Again, the child may refuse to move the bowel because of a spirit of negativism. He does not wish to be bothered and taken from his play, which interests him more. When placed on the stool, he simply refuses to make the effort and actually inhibits the movement. Of course, this practice, long continued, will bring the same results as that in which the child does not take sufficient time to obey the rectal impulse. It takes very wise handling of the child to eliminate this negativistic cause of constipation.

Another common fault at stool in older children is the presence of toys and reading material. This interferes with the voluntary part of the act that is necessary to bring about successful defecation. Children should be trained to concentrate on the act and have it over with quickly.

Atony of the Bowel.—Atony of the bowel may appear in an older child as the result of such conditions as severe anemia, a long illness, or nervous exhaustion. These conditions so sap the vitality of the child that general atony, including the bowels, occurs, and the child is left with insufficient power to move the bowels adequately. It is inter-

esting to see the neurotic child who is suffering with chronic exhaustion enter into play or other activities with great energy, only to be so fatigued and exhausted that when brought to stool he is physically unable to make the effort to move the bowels.

Lack of exercise may also be a factor in some children who do not have the opportunity to be much out of doors. This may often be in conjunction with faulty diet in that too much candy, sweets, meat, milk, and other foods which leave little residue, are given. There is a relative absence of cellulose containing foods, as fruits, vegetables, and cereals, which robs the bowel of that mechanical irritation necessary for good bowel evacuation. Often there is an insufficient intake of water, so that the bowel content becomes excessively dry because fluid content is absorbed to supply cellular needs.

Constipation is seen frequently in the child who has a poor appetite. So little food is taken, especially vegetable and fruits, that no residue is left in the bowel to stimulate peristalsis. Such a condition results in malnutrition, atony, and possibly nervous exhaustion, so that these factors also contribute to the problem and the vicious circle is started.

Enema and Cathartic Habit.—How frequently do we see mothers who feel that a weekly or biweekly cathartic or enema is necessary, whether the child needs it or not, in order to clean out the bowel. Each dose of cathartic or enema which disturbs the usual rhythm is usually followed by a day or two when no bowel movement occurs. This, continued long enough, produces atony and stasis, which requires more and more drastic cathartics and more enemas. There is deficient excitability of the mucous membrane due to the inflammation set up by the action of the cathartic chemical or the stretching action of the enema. Again, we see infants whose feeding is faulty, who receive milk of magnesia or other mild laxative daily in the formula in order to insure a daily bowel movement. If this is continued for long, more drastic cathartics must be employed to give the desired daily movement.

Cold and other infections are common in young children. Some parents and some physicians still cling to the exploded idea that such infections can be cured or adequately treated by purging the child. When one considers that colds are due to an infection either by virus or bacteria, the implantation of which is local, it stands to reason that such purging can have but little effect upon the cold and can but help to fasten the cathartic habit upon the child. Cathartics and enemas should be used at rare intervals in children. When necessary the drastics should be avoided.

Spastic Colon.—In some children we see a contracted colon, which is due to an autonomic imbalance. Here the stools are small and pencil- or ribbon-like in character. There may be small, round scybala, the stool resembling rabbit or goat feces. This spasticity may be seen in children presenting a neuropathic constitution. Peristalsis is lost to spasmodic contraction or there may be in-

action. This is brought on by such conditions as lead-poisoning, pain, as that caused by anal fissure or abdominal conditions, or irritation in the bowel, as that due to excessive roughage when bran, agar, and such substances are used in excess. Allergic sensitiveness also frequently causes such a spastic colon when specific substances are eaten by the child. The history of allergy and the relief of symptoms in the child, which comes when the offending article is removed from the environment, make the cause of this type of constipation certain.

* * *

II. DIAGNOSIS

HELEN B. PRYOR, M. D. (Stanford University Medical School).—Constipation may be considered a purely functional disorder in 85 to 90 per cent of cases. Consequently, the type of child most often seen with this complaint should be scrutinized.

In a study of factors involved in the hunger strike, so frequently encountered by pediatricians, it was discovered that most of the hunger strikers were also constipated.

Anthropometric measurements were done on one hundred such children and compared with an equal number of other children of the same age and sex. The measurements included, in addition to data, as age, sex, height and weight, diameters as follows: bi-acromial, lateral chest, bi-iliac, antero-posterior. Girths measured included circumferences of neck, chest at nipple line, upper arm at middle of biceps, calf at greatest girth. These measurements, when compared by age-sex groups, demonstrated that the children who were constipated, and habitually did not eat, were of linear-type body build, and had small and delicate bony frameworks when compared with the control group.

Certain anatomic and physiologic characteristics of linear-type people, as described by Thompson, Bean, and others, should be remembered in connection with constipated children.

Owing to the small thoracic outlet, the liver is low-lying, with a vertical inclination, and keeps mainly to the right side. For the same reason the stomach is low-lying, often below the umbilicus, vertical, and lying strictly to the left side; although, on lying down, it may rise somewhat and the pylorus may move to the right. The stomach is commonly J-shaped—the “fish-hook stomach”—and the important point to note here is that the lowest part of the stomach lies some considerable distance below the pylorus, so that the stomach is under the necessity of emptying itself against gravity. The stomach is markedly atonic, and this, together with the position of the pylorus, just mentioned, makes complete emptying a matter of some difficulty, and one which is often imperfectly performed.

Professor Bean has found that in this type the small intestine is unusually short, while the large intestine is very long. Because of the shortness of the absorptive small intestine, the food does not take so long to pass through it as in the other type, and, therefore, assimilation of nutriment is not so good. On this account, together with the

poor circulatory conditions, the general nutrition of these people is below par; they are thin, their musculature is poor, and their trophic functions are anything but vigorous.

This linear-type child often exhibits vasomotor instability characterized by easy blushing, cold extremities, rapid pulse, breathlessness on slight exertion; speech is usually rapid and sometimes stammering. Mentally, such a child is bright, often precocious; but he changes restlessly from one occupation to another, showing fatigue rapidly and lack of concentration.

A nervous, high-strung child, who is often habitually constipated, is usually anemic, and has a very poor appetite, which constitute a vicious circle. The high-strung child of nervous parents, is often an only child, who is the object of too much undivided solicitude. He develops into the neurotic type of hunger-striker as a result of all the concentration upon his nutrition and elimination.

Since regularity of habits is so important in elimination, we sometimes expect to find constipation a complaint of the willful, spoiled child, who is permitted to be erratic about the performance of his duties.

The causes of constipation due to food include insufficient carbohydrates and insufficient total solids, while insufficient fluid intake results in hard, dry stools. Bottle-fed babies during their early months do not normally have the two to three large stools daily that the breast-fed babies have, but this does not constitute a constipated condition.

A high-fat diet is constipating because it causes stools containing a high proportion of soaps difficult to evacuate. A high-starch diet may be mechanically constipating, because it does not sufficiently stimulate the intestinal glands and the liver, thus slowing down peristalsis.

An anal fissure, or small erosion, should be considered in diagnosing the cause of constipation. In such a case the pain produced by attempted evacuation is enough to cause a spasm of the sphincter ani and retention of feces. Unexpelled fecal matter is returned from the rectum to the sigmoid, producing stasis and dilatation.

Einhorn described constipation as due to retarded peristalsis, to enterospasm, or to abnormality of other organs. The degree of irritability of the bowel wall differs in different types of children. The linear type is more susceptible to spastic constipation.

Spasmodic contraction of the bowels may involve the small intestine, but the colon is chiefly concerned—the contraction being limited to a small segment. Forced feeding and overfeeding, in a conscientious effort to produce gain in body weight, irritates the intestinal tract.

Hertz described the reverse peristaltic wave in the large intestine, which mixes the contents of the transverse and ascending colon and returns accumulations to the cecum. The fluid is absorbed here. If there is too much roughage in the diet, masses of dry, undigestible residue are expelled

with great difficulty. This may cause spastic contraction of the bowel wall with an aggravation of the constipation.

In atonic constipation the cecum is most frequently involved, but sometimes the sigmoid also becomes atonic and dilated because of stasis. The muscular coats of the bowel wall become stretched and lose their power of elasticity, finally allowing dilatation.

Imperfect integration of the nervous system, following illness, interferes with nervous impulses essential to normal action and may affect either the upper or lower bowel.

* * *

III. TREATMENT AND PROGRESS

WILLIAM ANTHONY REILLY, M. D. (University of California Medical School, San Francisco).—The treatment of this common complaint includes training, diet, exercise, and drugs—placed in that order of importance. Training and establishment of a good routine is a great help in establishing the habit of a regular bowel motion, especially in a young child or infant. The emptying of the lower bowel can usually be made a habit in an infant under one year of age as well as taking a nap or having hours for meals. The mother should preferably watch for the usual hour of movement in a child, even only three months old. If the hour is regular, this will prove to be relatively simple. Sitting the child on a small receptacle placed on her lap for five or ten minutes, and gently massaging the lower abdomen in clock-wise direction, will frequently establish the habit. If more than one movement occurs at reasonable hours, the same procedure can be carried out. It is well to explain, even to the infant, with some simple word the purpose of the procedure; often the infant later on imitates this word and the mother can "catch the child in time." With children older than three or six months the same routine should be instituted. If a child reaches one year of age without any set time for a movement, the mother should put the child on a small receptacle, chair, or special toilet seat for the purpose, and try thus to establish a regular hour. Some children prefer to use an adult toilet; others may want to climb onto the seat; a few prefer only to be taken to the room, a few want to go there by themselves.

Permitted indulgence in such idiosyncrasies will often reward the mother with less washing of diapers, etc. If an adult toilet is used, a small infant seat should be procured; one can easily be made from a smooth board and padding the edge. To start a motion it is harmless to insert gluten or cocoa butter suppositories; or even hand-made pure soap suppositories; greased glass rod, oiled paper cone, or even the cotted-greased little finger. This is often done for the first week or two of training; such usage is gradually lessened, the interval increased, and it is then possible to discontinue it and a regular movement time often will have been started. In older children it is very important that they take a regular time for defecation; this is doubly true if the impulse occurs

during play. Probably many constipated older children would be thus relieved; mothers should call them from play at the expected time. Continued failure to heed their impulse probably often results in colonic atony.

Diet is the second item of importance. It, as well as the other items mentioned in the first paragraph, should be quite closely integrated. Breast milk is usually more conducive to bowel motions than artificial feedings. With a breast feeder, pure prune juice or orange juice as a supplement will often relieve infrequent movements; extra water also helps to soften the motions. The mother should realize that a nursing can go twenty-four hours without a movement as long as there is no discomfort from colic, distention, etc. Toxic absorption is so rare, and the evil of laxatives, enemas, etc., so common, that it is well to explain these facts thoroughly to the worried mother. I have seen a breast-fed baby go seven to eight days without a motion, still act well and, finally, pass a soft motion. Nurslings often strain in passing hard feces which, in excoriating rectal mucosa, are streaked with bright red blood. Extra fluid to soften the feces, perhaps a suppository or a syringe-load of mineral oil, will do likewise.

Artificially fed babies are more likely to have trouble with their feces—hard and infrequent motions, gas pains, or restlessness. Of course, 10 per cent, or even 15 per cent, carbohydrate should be added to the formula in the form of more of the added sugar or substituted by other sugars. (Table sugar is pure, good, and often laxative). Malt extracts are fine—the old malt soup extract should be used more often; honey or molasses, one to two drams to a feeding, often help. The finest available dextrin and maltose products often must be changed. After the addition of solid food to the diet, this extra residue, if not too great, often improves this complaint. Finely chopped meat or vegetables does help when they are started in the infant's diet. Fruit is well known for its laxative effect. A one and one-half to two-year-old child still having strained smooth food may have relief from constipation by gradually offering unstrained items, plenty of unstrained fruit, whole-grained cereals, even two or three tablespoons of bran at a meal, as muffins, bread, or cereal. This increased roughage may prove to be the desired solution. The amount of roughage, of course, can be overdone and aggravates constipation. Do not forget that weight-for-weight milk leaves more bulk for feces than most other foods. Thus, too much milk in some youngsters can acutely aggravate this problem. In older children the same above facts hold true. Fermented milks often help them, also generous helpings of honey, or molasses (even the raw varieties of cereals may relieve milder complaints).

The need for exercise is quite obvious and very beneficial. General types—running, jumping, wrestling, riding bicycles, etc., are, of course, helpful in "toning up" all muscles, and this includes those of the colon. Occasionally it is necessary to locally exercise abdominal muscles. Passive exercise by kneading, rotatory clockwise movements,,

etc., all are also helpful. Special active exercise for the abdominal wall—as flexing trunk, stiff leg-raising in recumbency—will be needed in indicated instances.

Purposely, drugs for constipation will be very sketchily mentioned. They should only be used to relieve in acute cases needing immediate relief or for the cases not responding to other procedures. Suppositories are relatively harmless, should be used as are enemas—before a medication by mouth—since the difficulty usually is an inability to empty the large bowel and not to move the small bowel. Gluten or cocoa butter are usually harmless, but slower in action than the more irritating but safe and rapid-acting soap or glycerin sticks. Suppositories often help to train an infant. Enemas are helpful to relieve an acute complaint; or more often for chronic instances or impacted feces. Often in infants, three or four syringefuls (one ounce each) will be followed by a movement. Usually a teaspoonful of salt to a pint of tepid water is the mixture. One or two ounces of mineral oil or olive oil often lubricate hard feces, so that the infant stops laboring and easily expels previously hard feces. In children over a year, more volume of and pressure by the enema may be needed. Do not be afraid to use an enema bag with the small pencil-sized greased tip; it will not hurt or stretch the sphincter any more than a suppository will. Several quarts to a gallon may be necessary; two to three feet of hydrostatic pressure are sufficient; let it run in by pint fractions, having the child seated on a basin or pan and hold this amount for two or three minutes, if possible, before expulsion. Impacted feces are best handled by one to three quarts enema of oil once or twice daily or alternating with soap-suds water, until softening allows of digital removal of feces. In this instance, milk of magnesia, aromatic fluid extract of cascara, A. B. S. C. pills, or compound cathartic pills, may be temporarily used.

Mineral oil, or milk of magnesia (for an infant, drams one or two at night, or ounces one-half to one for older children); agar for older children in one- or two-dram doses on their food once or twice daily, are the more reliable and harmless drugs. They are best used temporarily in acute conditions; or may be used more often in untractable cases. Senna, aloes, rhubarb, should be avoided if drugs have to be used continuously. If drugs must be used, they should gradually be dropped as training, diet, and exercise become effective.

One must always bear in mind that the more severe and untractable cases should have possibly careful physical, fecal, rectal, proctoscopic, and roentgen examination. Anatomic anomalies may exist and several of them should be borne in mind because they can be alleviated surgically. Among these are Hirschsprung's idiopathic megacolon and rectal mucosal valves. The former is revealed by the tremendously large abdomen, large infrequent stools, x-ray, and spinal anesthesia tests; the latter by the proctoscope. Anal stenosis causes ribbon-like stools. Proctoscopic and digit will expose rectal fissure, easily relieved by silver nitrate stick cautery. Other frequent anatomic causes are

weak abdominal muscles following poliomyelitis or rickets, etc.; colonic muscle atony from frequent enemas, etc.; colonic spasm in nervous children.

Prognosis.—In general, the average constipation in infants is mild, shortlived, and may be expected to respond to therapy and disappear quite completely in about two or three months. Naturally, older children constipated since early infancy are slower to improve. The greater the degree of constipation, usually the longer the time and the more difficult to attain good results. Nervous, high-strung children with overwrought mothers and family do not usually respond readily to treatment. Often, though, apparently more difficult cases will respond quite quickly and with quite permanent results. The more desirable results are attained by full coöperation of mother and patient. Often an assuring talk to the mother, that milder degrees of constipation will not hurt the child or that what she calls constipation is not really so serious, will favorably alter the outlook.

Signs of Active Rheumatic Fever.—Massell and Jones base their remarks on a study of 178 patients with active rheumatic fever. In 163 of these cases an analysis has been made of the routine laboratory tests and a comparison made of the leukocyte count and erythrocyte sedimentation rate in respect to their value as tests for active rheumatic fever. Also the clinical manifestations have been analyzed in seventy-three patients with clinical evidence of rheumatic fever, and the relation of laboratory tests to the clinical signs has been determined. The leukocyte count and corrected sedimentation index are helpful and often essential for the determination of low-grade rheumatic fever. In the majority of instances, after the clinical manifestations of the disease subsided, one or both of these tests continued at an elevated level for from several weeks to many months. As tests for low-grade rheumatic fever, the corrected sedimentation index and leukocyte count are of about equal value. In view of the large percentage of error in the technique of the leukocyte count and the necessity for repeated counts, the corrected sedimentation index is more valuable as a single, isolated test. One or both tests may be normal in the presence of clinical signs of rheumatic fever. Corrected sedimentation index determinations are of no significance in the evaluation of active rheumatic fever if performed within two or three weeks after an infection of the upper part of the respiratory tract or tonsillectomy. Neither the leukocyte count nor the corrected sedimentation index is a specific rheumatic fever test, but must be interpreted with regard to other considerations. In rheumatic fever subjects, repeatedly elevated leukocyte counts and rapid corrected sedimentation indexes should be considered indicative of subclinical rheumatic fever in the absence of any other cause for their abnormality.—*New England Journal of Medicine*.

Let's See.—Activities of the National Society for the Prevention of Blindness, Inc., 50 West Fiftieth Street, New York City, during the past year were more widespread than at any time since the organized campaign for conservation of vision was started in 1908, it is pointed out in the annual report of the Society, entitled "Let's See!" made public by Lewis H. Carris, Managing Director.

"Men and women in every walk of life throughout the United States are now participating in the movement to safeguard eyesight," Mr. Carris commented. "The project which has grown into such proportions began originally as an effort of a New York State committee to cut down the amount of babies' sore eyes at birth; this modest beginning has grown into a national organization engaged in combating blindness or impairment of vision of any sort and at every age of life.

"The underlying cause of blindness, whether it be the result of disease or accident, is usually ignorance. Our work, therefore, is concentrated largely on pointing the way. We try to keep abreast of the scientific advances in medical and pedagogical knowledge and to inform the public in popular language of such advances and how they may be applied practically in preventing blindness and in saving sight."

Among the items of information in the report are the following: 350,000 copies of the Society's publications were distributed in 1936; the motion-picture film, "Preventing Blindness and Saving Sight," was viewed by 90,000 persons; 120 displays and exhibits were provided for medical, educational and welfare conventions, and for county fairs; and staff members of the Society visited eighty-eight cities in twenty-seven states, in connection with services to local communities.

Realizing the fundamental importance of the medical profession, the Society maintains the closest relationship with ophthalmologists and public health physicians, as well as with general practitioners. The Society also maintains close relationship with schools and teacher-training institutions; and it coöperates with nurses, safety engineers, illumination experts, governmental and private health agencies, and various civic groups.

The Society's income in 1936 was \$122,000, and its expenditures amounted to \$142,000, necessitating the use of \$20,000 from the reserve fund. Financial support is received through voluntary contributions from approximately twenty thousand members and donors in all parts of the country.

"The unspoken plea of blind babies, 'Let us see,' inspired the founding of our National Society for the Prevention of Blindness," says William Fellowes Morgan, its president, in a preface which explains the title of the report. "At that time, 28 per cent of the children in schools for the blind in the United States were there because of 'babies' sore eyes' (ophthalmia neonatorum). Public information, followed by public action, has resulted in a 75 per cent reduction—a remarkable achievement."

Should Men Be Declared Old?—Lately there has been a tendency to declare men old by legislation, forgetting, of course, as someone once said (we forget who): "Nobody grows old by living a number of years. People grow old by deserting their ideals. Youth is not a time of life; it is a state of mind."

Benjamin Franklin at the age of sixty-nine presided over the Constitutional Convention of Pennsylvania. He was also elected one of the committee to frame the Declaration of Independence and was one of its signers. When seventy years old he was sent to France as one of the three commissioners seeking food, money, arms, and military alliance with that country. And he met with signal success. In 1781, at the age of seventy-five, he was appointed a member of the commission to negotiate a treaty of peace with England. Not satisfied with this, four times after reaching seventy-nine he was elected president of the Commonwealth of Pennsylvania.

Another great statesman, Benjamin Disraeli, entered his second premiership of England at the age of seventy. Old as he was supposed to be, it was due to his political acumen that England, in 1875, obtained a half-ownership in the Suez Canal, and that Queen Victoria in the following year was crowned Empress of India.

In 1887 Giuseppe Verdi produced his opera, "Otello." He was then seventy-four years old. In 1893, when eighty years of age, he produced his next subject, "Falstaff." This was his last and greatest opera.

Thomas Edison lived to be eighty-four. His inventions numbered over a thousand. He labored incessantly despite the handicap of almost total deafness. One of his last achievements just before his death was a process for manufacturing rubber from goldenrod.

And so it goes. Were space available we could mention many others whose greatest accomplishments were produced as they sat in the light of the setting sun.—*Milwaukee Medical Times*.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

EDWARD M. PALLETTE.....President
HOWARD MORROW.....President-Elect
W. W. ROBLEE.....Speaker
MORTON R. GIBBONS.....Council Chairman
FREDERICK C. WARNSHUIS.....Secretary-Treasurer

THIS MONTH'S TOPICS* ASSOCIATION ACTIVITIES

1. *Minutes of Special Meeting of the Executive Committee.*
2. *Minutes of Joint Conference of Committee on Public Policy and Members of the Council of the California Medical Association.*
3. *Los Angeles Society Bulletin.*
4. *A Valley Trek.*
5. *Board of Medical Examiners.*
6. *Association Endowment Fund.*
7. *Sixty-Sixth Annual Meeting.*
8. *Hospital Service.*
9. *Members Are Bound by Their Society Constitutions and By-Laws.*
10. *American Medical Association.*
11. *Chairman of Board of Trustees and the Secretary of the American Medical Association Visit San Francisco.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Things Well Worth Thinking About.*
2. *An Evasion Racket.*
3. *The "Pay" Patient Plan Should Not Be Approved.*
4. *Foreign Graduates.*
5. *What Compulsory Health Insurance Under House Bill No. 622 Will Cost in Pennsylvania.*
6. *Clinical Problems in Syphilis Control Today.*
7. *The Serodiagnosis of Syphilis.*

ASSOCIATION ACTIVITIES

CALIFORNIA MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

Minutes of a Special Meeting

1. A special meeting of the Executive Committee of the Council of the California Medical Association was held in the Association offices in San Francisco on Sunday, April 11, 1937.

2. The meeting was called to order by the chairman, Karl L. Schaupp, with the following quorum present: Karl L. Schaupp, E. M. Pallette, Howard Morrow, Morton R. Gibbons, W. W. Roblee, George H. Kress, and Secretary F. C. Warnshuis.

3. **Waiver.**—All members present signed a waiver of required notice of meeting.

4. **Committee of Five.**—Discussion was had upon the report of the Committee of Five, the conference with the Board of Health, and the requests of Dr. J. B. Sharp, Director of Projects of the WPA.

William W. Roblee, supported by M. R. Gibbons, presented the following resolution:

Resolved, That the Secretary be directed to advise the State Board of Health that the California Medical Association

is in agreement with the Board of Health's plan and procedure regarding the preparation and publication of the report of the Committee of Five as outlined in the letter of Dr. James B. Sharp to Professor Paul A. Dodd, dated March 22, 1937, in which regulations for publication of statistical survey and research materials were transmitted.

The Secretary was instructed to request the State Board of Health to submit its suggestions and recommendations as to the publication and disposal of the report of the Committee of Five.

Upon receipt of this communication the officers of the Association are to call and hold a meeting with the Committee of Five and complete the details for the publication of the final report.

This resolution was adopted without a dissenting vote. Meeting adjourned.

KARL L. SCHAUPP, *Chairman.*
F. C. WARNSHUIS, *Secretary.*

* * *

COMMITTEE ON PUBLIC POLICY AND COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of a Joint Conference

1. At the request of the Committee on Public Policy and Legislation a joint conference was held with the Council in the offices of the Association in San Francisco on April 11, 1937. This meeting was in the form of an advisory conference for the reason that the emergency did not permit giving the notice required by the by-laws for a special meeting of the Council.

2. The conference was presided over by Morton R. Gibbons, with the following present: Morton R. Gibbons, E. M. Pallette, Howard Morrow, William W. Roblee, George H. Kress, Henry Rogers, Calvert Emmons, Karl L. Schaupp, W. H. Kiger, O. D. Hamlin, Carl Howson, H. J. Ullmann, A. E. Anderson, T. Henshaw Kelly, J. B. Harris, F. C. Warnshuis.

By invitation: Honorable P. J. McMurray, Honorable Melvin Cronin; Doctors F. R. Makinson, W. E. Mitchell, Rodney Yoell, and Mr. Howard Hassard.

3. T. Henshaw Kelly presented an outline of a proposed reply to an article that appeared in a national magazine.

After a general discussion it was the advice of the conference that the proposed reply should not be sent in or over the name of the California Medical Association.

4. J. B. Harris, Chairman of the Committee on Public Policy and Legislation, presented an extended report on the legislative situation, the tremendous pressure that was being brought by several influential groups for health insurance legislation, amendments that were being submitted and the concentrated effort that was being made to pass Assembly Bill 1283. Doctor Harris suggested certain amendments to safeguard the interests of the public and the medical profession. Advice was requested.

Statements were made by Honorables P. J. McMurray and Melvin Cronin and Doctors T. Henshaw Kelly and Rodney Yoell.

The entire question and related factors were discussed at length by all present. The Chairman called upon Doctors W. E. Mitchell and F. R. Makinson for further discussion.

5. On motion of George H. Kress, supported by Henry J. Ullmann, the following resolution was adopted unanimously:

Resolved, That this conference go on record as being in favor of the commission form of supervision in a

* All articles listed under the caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

proposed medical service law, such as "S. B. 605" or "A. B. 1283"; and be it further

Resolved, That the Committee on Public Policy and Legislation feel free to consult with a special committee composed of the President, President-Elect, the Speaker of the House, and the Chairman of the Council, in any emergencies that may arise in these matters, and on changes or modifications in the proposed health insurance.

6. The conference adjourned at 1:30 p. m.

MORTON R. GIBBONS, *Chairman*.
F. C. WARNSHUIS, *Secretary*.

LOS ANGELES SOCIETY BULLETIN

For some time watch has been kept on other bulletins and journals, state and nation, for commendatory comments upon the Los Angeles County Medical Association's Bulletin which several weeks ago came out in new size and typographical make-up. Its form, make-up, and contents is believed to be so meritorious that it was hoped that others would be moved to take notice and express approbation. It was intended that these comments could be quoted as a text for this item in congratulating one of our constituent county units. Alas, thus far they have been conspicuous by their absence.

It was some thirty years ago that we first assumed charge of publishing a county bulletin—one of the first in the country. Since then there has been noted a gradual growing list of county bulletins. Some continue in their original style and contents. Others have acquired new and more pleasing form and make-up. Some embrace the opportunities that confront them, while others are merely program copy, clippings, and "ads" of good and unwarranted copy. Some are issued under a printing syndicate, the copy being the same in all except for the local program and an occasional report. The syndicate makes the profit that the county foregoes because local men decline to assume the duties and give a bit of time to editorial and business management. Some societies cause their bulletin to yield an annual profit of from a couple hundred to several thousand dollars. Last year the Los Angeles bulletin yielded a net profit of over \$7,000—an income that helps defray laudable activities that could not otherwise be undertaken, and members profit therefrom.

It is suggested that other units in this country benefit from the initiative and policies exemplified by the Los Angeles bulletin. With one or two exceptions, every bulletin can be made more pleasing in appearance and more interesting and achieving in its contents matter. And that's that.

To our Los Angeles County Association there is extended earnest words of congratulations and commendation. Pride is taken in their initiative and in the able editorial and business management that is manifest in each issue. A real service is being rendered to the members, and community respect and recognition is being demonstrated. Congratulations again, more power to you, and keep on being a pacemaker for other bulletins.

A VALLEY TREK

On March 16, Councilor Axel Anderson and the State Secretary visited the Merced County Society at noon. There was a goodly luncheon attendance during which there was a question and answer conference. Following the luncheon, Councilor Anderson and the State Secretary discussed several of the major activities of the Association and legislative problems that are confronting the Association. It is always inspiring to meet these members, who are alert to the interests of their community and the rendering of adequate and competent medical care. The Merced Society earnestly and unitedly conform to the policies of their state organization and commendably discharge their component unit obligations.

Following the Merced meeting the trek was continued to Fresno, where at 4 p. m. an informal discussion was had with a number of members of that society. At six o'clock the trek was resumed, with the destiny Hanford, Kings County. Here, at 7:30 o'clock, fourteen members gathered around a delicious dinner. Kings County has a membership of eighteen. Situated in a rich valley section, thirty-four miles from the main highway, these members are quite distant from medical centers. In consequence, difficulties have been experienced in arranging varied

scientific programs and it has been necessary to rely upon their members to a large extent. Councilor Anderson advanced some very constructive suggestions. There then followed a two-hour discussion of organizational policies and local application. Here again it was most gratifying to mingle with a group of members who are diligently striving to maintain the purposes of organization. The night was spent in Fresno, and an early start was made for Sacramento.

On Wednesday evening the Sacramento Society for Medical Improvement held its sixty-ninth annual banquet. As usual, the Banquet Committee had for weeks been rehearsing its after-dinner program that has always been an outstanding feature of these annual celebrations. Chairman Scatena and the Board of Directors, in respect and in honor of Dr. Charles B. Jones, whose sudden death, and funeral on the day of the annual banquet, canceled the "stunt program" and dedicated the annual dinner in memory of Doctor Jones. Some eighty-five members gathered at the Sutter Club. Following a most appetizing dinner, the Doctors Quartet rendered several selections. Doctors can sing. Informal remarks were made by Doctors Wallerius (president) and Scatena and Councilor Schoff. State Secretary Warnshuis substituted his original remarks as guest speaker because of the altered program, and made a response under the general subject of "The Sidewalks of Medicine." President Wallerius then adjourned the banquet in honor of and in respect to Doctor Jones. There followed an enjoyable hour of informal renewal of friendship with the members of this, the oldest, constituent unit of the State Association. Then to bed, but not to sleep because of the riotous doings in corridors and rooms that seems to be a common occurrence in the Capital hotels during legislative sessions with groups and interests seeking to gain legislative favors or exerting pressure influence upon legislators. Hotel managers would do well, if they expect to hold patronage, to direct such celebrants to night clubs. Early morning breakfast, and the old car was pointed toward headquarters and a desk of four days of accumulated mail.

BOARD OF MEDICAL EXAMINERS

The 1936 annual report of this Board contains some interesting facts. A detailed report is given upon the exposure and prosecution of the so-called Pacific Coast abortion ring. The Board and other authorities merit every praise for their efficient efforts in bringing into court this gang of racketeers.

During 1936 the Board issued 590 certificates to practice. Rights to practice were restored to two licentiates. In the written examinations, nineteen applicants failed to gain passing grades. Of eight drugless practitioners, three failed. The majority of failures were among graduates outside of California, foreign medical schools. The California Board is to be congratulated upon the care taken in conducting these examinations, which record is not duplicated by many boards of other states.

In connection with this it should be noted that members of the faculty and students of certain Canadian schools filed protesting petitions with the present legislature because foreign-school graduates desiring to apply for a California license are compelled under law to spend a fourth year in an approved American College. The petition sought to obtain an exception for Canadian graduates. This would be class legislation, hence illegal. Dr. William R. Molony, President of the Board, has well stated: "I am of the opinion that there is ample opportunity in American medical schools for the needs of American people, and we should not worry over the problems of those who choose to take their medical studies in foreign countries."

Reciprocity licenses were granted to 166 applicants, New York and Illinois having the largest number. Sixty-four California licentiates sought endorsement to practice in other states.

During the year thirty-four licentiates were listed for hearings on charges involving unprofessional conduct. Of these, eleven had their licenses revoked; one suspended; fourteen on probation; two dismissed; six, action is still pending. In spite of repeated warnings, there are those who feel that they are exempt from the governing laws. Narcotic law violators head the list. Physicians are ad-

vised to observe the letter as well as the spirit of the law if they are desirous of escaping prosecutions for infractions.

During the year, 229 licentiates died in California or elsewhere.

The total income in fees and tax was \$56,475.87 and disbursements, \$54,134.26. It is pertinent to comment that this is a penurious budget, limited as it is by the Legislature, for the protection of the health welfare of the public. Here is a state board, created solely in the interests of the people, compelled to function with a minimum amount of funds. This budget should be triple in its present amount. The State nor the people do not contribute one penny of these funds; the total is derived from fees paid by applicants to practice. The least that should be asked from tax-derived funds is that the State should match these fees with a like appropriation and give this board \$112,000 for operating expenses.

We are proud of our Board of Medical Examiners, its members, secretary, and administrative officers. We appreciate the reputation they have gained in this country and the efficient manner in which the Board functions. Its ten medical members give generously of their time and ability, unremunerated except for a per diem pittance, for the purpose of maintaining high educational standards among those who engage in medical practice. The public is the beneficiary of these services rendered by these Board members. Our members' thanks and gratitude are tendered to this Board.

ASSOCIATION ENDOWMENT FUND

In several past issues, discussion was had of an Association Endowment Fund. Its legal set-up, purposes, and forms for bequests were described. Pointed suggestions were made that members financially capable, make contributions to this fund. To date not a single nibble, comment, or subscription contribution has been received.

More emphatic suggestions are, apparently, in order.

Purpose.—To create a permanent fund, the principal to remain intact in perpetuity. The interest earnings of the fund to be used to finance expanding Association activities such as postgraduate conferences, public-health education through a speakers' bureau, health institutes, medical museum, and historical records and public relations and legislation.

Contributions.—To establish such a fund that should eventually amount to \$500,000 or more, contributions are solicited from members as well as lay persons. Any amount from \$100 to \$10,000 will be gratefully acknowledged. Brother, how much will you contribute? Having sent in your contributions, it is suggested that you cause that lay friend of yours to send in his contribution. Will you do your part? Thanks.

SIXTY-SIXTH ANNUAL MEETING

This issue will reach our members' desks shortly after our sixty-sixth annual session has ended in Del Monte. The forms went to press the first of May.

Following each annual session it requires about one month to transcribe the minutes and prepare copy for the printer. In consequence, the July issue will contain the record of our 1937 session. A terse summary will be compiled for the June issue in order that the members may gain an early insight of the highlights that characterized the Del Monte session.

HOSPITAL SERVICE

During last year 8,646,885 persons were admitted to hospitals in the United States. Likewise, 831,500 babies were born in hospitals. There are available 1,096,721 hospital beds.

In California 70.4 of available beds were occupied. In this State there are forty church-controlled hospitals with 4,558 beds. Fraternal organizations own three hospitals with 346 beds. Nonprofit organizations operate sixty-six hospitals with 5,563 beds. There are 226 hospitals with 27,054 beds in California, and these admitted 490,575 patients during the year. The average daily census was 19,056. Technicians to the number of 418 were employed by 183 hospitals.

Two hundred and ninety-two radiological technicians were employed by 182 hospitals, and 222 dietitians were employed by 145 hospitals. There were enrolled 2,694 student nurses in 145 hospitals.

Deaths reported by 261 hospitals totaled 23,814. Hospitals which refused registration were 72 with 2,391 beds.

Thirty-four approved hospitals had 435 interns, of whom 389 received a salary that averaged \$29.19 monthly.

These are some of the figures found in the *Journal of the American Medical Association* hospital number of March 27.

MEMBERS ARE BOUND BY THEIR SOCIETY CONSTITUTIONS AND BY-LAWS

The Supreme Court of the State of Washington has handed down some very pertinent declarations related to obligations of members set forth in the constitutions and by-laws of the organizations in which they hold membership.

Furthermore, the constitution, charter, and by-laws of the medical society constituted a contract between the members of the society enforceable in the courts if not immoral or contrary to public policy or the law of the land. The two physicians, as members of the medical society, were required to obey the by-laws of the society or subject themselves to the penalty of suspension or expulsion from the society, and it is not material how selfish or unselfish the objects of the medical society may be. That the medical society had the right to adopt the by-law with respect to contract practice cannot be questioned. Whether such by-law was just, reasonable or wise is a question of policy which concerns only the medical society and its members. The society, in the enforcement of its by-laws for the direct purpose of benefit to itself and to its members, is not answerable for damage incidentally resulting to a third person. So long as membership in the medical society continues, the member can be compelled under his contract with the society to obey its laws, rules and regulations, or suffer the penalty of fine, suspension or expulsion.

The enforcement of a by-law such as the one here involved, continued the Court, does not amount to unlawful coercion. *Seymour Ruff & Sons, Inc. vs. Bricklayers', etc., Union*, 163 Md. 687, 164 A. 752.

An association, in pursuing its legitimate objects, has the right to coerce a member by fine, suspension or expulsion, and the association will not, nor will its members, be liable in damages to those who may be directly or indirectly injured by such efforts. So long as a member remains in the association, he is subject to the coercive effect of a penalty exacted for breach of a by-law of the association. If he does not desire to abide by the obligations of his contract of membership, he may abandon his membership. No rights of the plaintiffs in this case, who were nonmembers, were invaded by the medical society when it established its code of ethics and insisted on compliance therewith through threat of expulsion of an offending member, and the enforcement of solidarity by threat of expulsion of the two physicians created no cause of action for the incidental damage resulting to the plaintiffs.

These opinions should clarify a much discussed section of by-laws governing membership. They clearly declare that members must abide by the conditions that govern membership.

AMERICAN MEDICAL ASSOCIATION

The annual session of our national organization will be held in Atlantic City the week of June 6. Members are advised to consult the issue of the *Journal of the American Medical Association* which contains the official program.

It is quite important that hotel reservations be obtained in advance by writing to the chairman of the Committee on Hotels, Convention Bureau, Atlantic City.

CHAIRMAN OF BOARD OF TRUSTEES AND THE SECRETARY OF THE AMERICAN MEDICAL ASSOCIATION VISIT SAN FRANCISCO

On April 13 Dr. Rock Sleyster, Chairman of the Board of Trustees, and Dr. Olin West, Secretary and General Manager of the American Medical Association, made a visit to San Francisco. The purpose of their visit was to survey the auditorium and hotel facilities of the city in order to report thereon when the invitation to hold the

1938 American Medical Association meeting in San Francisco is considered at the Atlantic City meeting this June.

These national officials were met in Oakland on arrival of their train by Doctors Reinle, Dukes, Makinson and the State Secretary, and welcome greetings were extended. The trip was then made across the Bay Bridge, and the day was spent inspecting auditoriums and hotels.

In the evening an informal dinner was tendered to the distinguished visitors. Present were officers and members of adjacent county societies. President-Elect Howard Morrow presided and he, together with Dr. T. Henshaw Kelly, President of the San Francisco County Society, H. Gordon MacLean, President of the Alameda County Society, Morton R. Gibbons, Chairman of the Council, J. C. Geiger, Director of Health, extended cordial fraternal greetings. Responses were made by Doctors Sleyster and West.

For fully an hour Doctor West commanded the intense attention of all as he imparted comment and observations upon present trends in social and legislative circles of state and national bodies and society. His plea was for courageous and sound thinking and action on the part of all members of the profession. The need for concerted unity of action for the future good of the public and the profession was emphasized. Individualistic and independent group pronouncements that were unauthorized, unofficial and at variance with adopted policies of organized medicine, was declared to be subversive to the ideals, objectives and progress of medical science, practice and service.

The following morning was spent in a further inspection tour, and at noon the members in Oakland tendered a luncheon at the Claremont, attended by thirty members, and presided over by President MacLean. Doctor West discussed some of the problems of medicine and public health.

These visitors gained a partial insight as to conditions in California and promised, at some future time, to make a more extended visit.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Things Well Worth Thinking About

Organize a Medical Service Bureau as a part of your county society. This bureau to aid your patients in determining their ability to pay for medical service and to advise them how to budget these expenses.

Organize a Speakers' Bureau and provide opportunity to gain experience in effective public speaking. Los Angeles County is conducting a most commendable as well as successful Speakers' Bureau. We need better and more public speakers.

Plan joint meetings with your county dental, health and bar organizations. Better understandings will result.

How about another summer picnic or field day? And make it a day for inter-county fraternization.

How about checking up on the social service work of your local and county hospitals for the purpose of ascertaining whether they are functioning efficiently and effectively.

Let the people of your county learn about the total amount of free and charity work done by your members a year. As a rule this amount exceeds the total charity contributions in your county but the people are not aware of this fact. Publicity is indicated.

If these suggestions are initiated and sustained in your county, your society will experience meetings made more valuable by an aroused interested membership. Someone has to pitch the first ball. Why not you?

†The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

An Evasion Racket

Courts have decreed that corporations cannot practice medicine or contract to supply medical service. This ruling has terminated attempts on the part of certain compensation insurance companies from openly employing medical men on a monthly salary basis to render medical care to the employees of firms covered by their insurance coverage.

Reports now are on hand that these certain insurance companies have resorted to a new undercover form of law evasion. This evasion is operated in the following manner. The company engages usually a young surgeon on a monthly salary basis. Instructions are given him to rent ample quarters, engage nurses, a stenographer to make out records and reports, purchase physiotherapy equipment, etc. Firms covered by this company are instructed to send injured employees to this hired agent surgeon. The surgeon is instructed to bill the company on the first of the month for all services rendered at compensation fee schedule rates. By the 5th or the 10th the surgeon receives a check but he is instructed not to cash this check. In a day or so a company representative calls and picks up this check. He gives the surgeon, cash or draft to pay rent, monthly pay roll and office overhead and surgeon's monthly salary. This later transaction is, of course, under cover and the surgeon can claim he is doing compensation work under fixed approved fee rates.

The scheme is illegal, evasion of laws, contract practice and insurance company corporate practice. The surgeon makes himself liable to revocation of his license and the insurance company to illegal corporate practice penalties.

The matter has been called to the attention of the Compensation Commission, the Insurance Department and the Board of Medical Examiners. Steps will be taken to end this racket. Members are requested to send in information that they may have so that it may be turned over to investigators. Such reports will be held in confidence and the informant will not become involved. Members should aid in terminating this corporate racket.

Consideration is being given to the amending of the compensation laws along lines recently enacted in New York. Right now you are asked to aid in presenting evidence and facts.

Foreign Graduates

Los Angeles, Calif., March 22, 1937.

William D. Cutter, M. D.,
Secretary, Council on Medical Education,
535 North Dearborn Street,
Chicago, Illinois.

Dear Doctor Cutter:

I have a copy of your letter to Dr. Warnshuis in regard to foreign graduates who desire a California license. I am sure that no one will disagree with you in your estimate of Canadian standards and standards of Class A Canadian Medical Schools. California along with the American Medical Association and many other states sees the danger in permitting graduates of low grade schools, located in foreign countries, to enter the practice of medicine without some additional evidence of education and training. Therefore, the law was so amended and the house of delegates passed a resolution to the effect of requiring these additional credits.

In order that the law be not declared unconstitutional, it must be all inclusive and not have a provision therein exempting one foreign country from the provisions of the act.

If it were legal for the Board to pass upon the individual, it would be very easy to enforce standards, but as you know this would be class legislation and clearly unconstitutional.

I am of the opinion that there is ample opportunity in the American Medical Schools for the needs of the American people and we should not be worrying over the problems of those who choose to take their medical studies in foreign countries.

Very respectfully yours,

WILLIAM R. MOLONY, M. D.

Compulsory Health Insurance

Massachusetts and Pennsylvania legislatures have under consideration bills proposing compulsory health insurance. The following excerpt presents some figures for Pennsylvania:

What Compulsory Health Insurance under House Bill No. 622 Will Cost in Pennsylvania

"Estimating Pennsylvania as producing 16.4 per cent of the national industrial pay roll, according to 1929 figures, the contributions would be as follows:

The State's contribution to be a tax equivalent to 1½ per cent of total payrolls throughout the State.....	\$ 70,739,760
Employers' contribution by payroll tax, 1½ to 3½ per cent (added to cost of production)	126,581,760
Employees' contribution by pay-envelope deduction, 1 to 3 per cent.....	85,637,520

A total annual sickness tax of.....\$282,959,040

"Allowing against the Pennsylvania figures of 1929 a reduction of 30 per cent as representing the accepted reduction in the present pay roll over 1929, we have:

The State's contribution to be a tax equivalent to 1½ per cent of total payrolls.....	\$ 50,035,440
Employers' contribution by payroll tax, 1½ to 3½ per cent of total (added to cost of production)	89,533,344
Employees' contribution by pay-envelope deduction, 1 to 3 per cent.....	60,572,880

A total annual sickness tax in Pennsylvania of\$200,141,664

COMPONENT COUNTY MEDICAL SOCIETIES

LASSEN-PLUMAS-MODOC COUNTIES

A meeting of the Lassen-Plumas-Modoc Medical Society was held at Westwood on March 26, following a dinner at the home of Dr. F. J. Davis, Sr.

Case discussions were held by the various members, and the winter's experiences discussed. It was decided that the past winter produced a bewildering variety of ear, nose, throat and respiratory ailments, and that it would be profitable to find an outside speaker on this subject for our next meeting.

Dr. W. C. Batson of Greenville was welcomed as one of our new members. F. J. DAVIS, JR., *Secretary*.

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SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society, held in the Medico-Dental clubrooms on April 1 at 8:45 p. m., President J. F. Blinn in the chair, was preceded by the customary dinner meeting, held at the Hotel Wolf Roof Garden. Fourteen members were present. Doctors H. S. Chapman and A. K. Merchant presented the paper at the dinner meeting.

A letter from the California Medical Association was read concerning the Intercoast Hospitalization Insurance Company.

Doctor Trick was accepted from the floor, on his application, to transfer from the Los Angeles County Medical Society.

The application of Dr. A. K. Merchant was read and referred to the Admissions Committee.

Mr. Thorpe of the Intercoast Hospitalization Insurance Company asked that an Advisory Committee be appointed to advise the Intercoast Hospitalization Insurance Company in this locality. He also told of the number of policies that he had sold, and told of the prospective buyers. Dr. Dewey Powell made a motion, seconded by Doctor Van Meter, that the appointing of an advisory committee be referred to the Board of Directors and that the Board of Directors be given full authority to act. The motion was carried.

A vote was taken on the motion made at the March meeting concerning the request of the California Medical Association for a change in the by-laws in the San Joaquin County Medical Society, that the sections in the local by-laws on the discipline of members be stricken out and the sections of the California Medical Association substituted. The motion carried.

Doctor Van Meter questioned the members as to whether they wished to have the May meeting put off until after the session of the California Medical Association at Del Monte. Dr. C. V. Thompson made a motion, seconded by Doctor Collis, that the next meeting be held on its regular meeting date. The motion carried.

On the invitation of the Lodi members, Doctor Broadus made a motion, seconded by Doctor Van Meter, that the June meeting of the Society be held in Lodi and that the Lodi members provide the paper and the entertainment. The motion carried.

Doctor Van Meter made a motion, seconded by Doctor Collis, that the resolution of the Tuberculosis Association relative to bovine tuberculosis be accepted and that copies be mailed to the members of the Legislature from this district. The motion carried.

Doctor Broadus reported on the progress of the Post-graduate Committee, and stated that he had a very fine program in the making for the next meeting.

The program was opened by Doctor Garrison, who read a paper on *Protamin Insulin* and its use. This was illustrated by lantern slides. Doctor Templeton of Oakland read a paper on *Malignant and Premalignant Lesions of the Skin*. This was profusely illustrated with lantern slides of the lesions and of the microscopic pictures.

There being no further business to come before the Society, the meeting was adjourned at 10:25 o'clock and refreshments served. G. H. ROHRBACHER, *Secretary*.

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SAN LUIS OBISPO COUNTY

The regular monthly meeting of the San Luis Obispo County Medical Society was held at the County Hospital in San Luis Obispo, March 20. Dinner was served to those present by the hospital staff.

An interesting program was presented by Doctors Harold Brunn, Joseph Dillon, E. L. Brown, H. Brodie Stephens, and Esther Rosencrantz of San Francisco.

Doctor Rosencrantz showed films of unusual cases of *Pulmonary Tuberculosis*, stressing especially military tuberculosis. She also showed a few cases of pneumoconiosis.

Doctor Brunn gave an interesting talk on *Lung Abscesses*, stressing their treatment, and illustrated the same with x-ray films.

Dr. E. L. Brown gave a talk on *Empyema and the Treatment of Empyema*, illustrated by means of slides and films.

Dr. Joseph Dillon spoke on *Bronchiectasis*, illustrated with x-ray films.

Dr. H. Brodie Stephens gave a paper on *Intrathoracic Tumors*, and illustrated his paper with slides.

During the forenoon of the same day a surgical clinic was held at the County Hospital, at which a number of surgical procedures for chest diseases was carried out.

E. D. ANDERSON, *Secretary*.

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SHASTA COUNTY

The last meeting of the Shasta County Medical Society was held in the Hotel Redding, at Redding, on March 8.

After a delicious luncheon, the Principal of the Cottonwood Grammar School presented the problem of infectious skin diseases in his school. He wished that the County Health Officer would go to the outlying districts and treat these skin diseases or allow the so-called Public Health Nurse to diagnose and treat. He was informed by the Society members that (1) the so-called Public Health Nurse is not licensed to diagnose or treat diseases; (2) that the county budget would not permit the authorization of a licensed doctor to go to outlying districts and treat these cases; (3) that the principal of a school in which such infectious children were in attendance should send those children home until they were returned with a note from a physician stating that they are free of an infectious disease; (4) if these infected children are of an indigent household, they should get a permit from their county supervisor and be treated in the clinic at the Shasta County Hospital.

A film was shown by a Libby, McNeil & Libby detail man concerning homogenized foods for babies and convalescents. Several films were then screened. The first was a film of the D. & G. Company, on the *Anatomy of the Male Genito-Urinary Tract*. The second was a D. & G. film on *Nephropexy*.

The matter of a delegate to the State Medical Association meeting at Del Monte was brought up. Dr. Henry L. White was elected delegate and Dr. Leslie J. Seeley was elected alternate.

The matter of the next meeting was then discussed. The secretary was instructed to contact a speaker for the next meeting.

Those present were: Doctors Olberg, Hansen, Kay, Saylor, Kay, Dozier, Trelstead, and Seeley. The guests were: Dr. M. J. Murphy, Mr. Eaton, Mr. Falkner.

The next meeting will be held at the Hotel Redding on Saturday evening, April 10, and the Society will be addressed by Dr. Dudley Smith, Clinical Professor of Proctology, University of California Medical School.

LESLIE J. SEELEY, *Secretary*.



TULARE COUNTY

The February meeting of the Tulare County Medical Society was held at Motley's Café, Visalia, on the 28th. Dr. R. C. Hill, President, presided.

Those in attendance were: Doctors P. D. Miller, Falk, Zeller, Weiss, Parkinson, Beck, Hubbard, Wenn, A. Miller, Cronmiller, Matthias, Betts, Zumwalt, Ginsburg, Rosson, Guido, McClure, Preston, Brigham, and Hellbaum.

Doctor Hill introduced Dr. Milton J. Hubbard, Chief of the Medical Division, United States Army Hospital at Sawtelle, as guest speaker of the evening.

Doctor Hubbard gave two papers—one on *Liver Abscess* and a second on *Experience with Protamin Zinc Insulin*.



A stated meeting of the Tulare County Medical Society was held at Motley's Café, Visalia, on Sunday, April 4, at 6:30 p. m. Dinner preceded the meeting.

In the absence of our president, Vice President Austin Miller called the meeting to order.

In attendance were: Doctors Fillmore, Bond, Guido, Watke, Matthias, C. A. Ambrose, from Visalia; Seiberth, Betts, Weiss, A. Miller, McClure, Campbell, Tourtellott, Kohn, Zumwalt, Brigham, P. Miller, Hellbaum, Rosson, Ginsburg and Frank Chamlee, of Hanford.

Guest speakers of the evening were: Dr. Frank E. McCullough and Dr. Philip J. Lipsett, both of Oakland. Doctor McCullough presented the first paper, *Injection Treatment of Hemorrhoids*. The paper was illustrated with a series of lantern slides to show the technique employed. The paper was of a practical nature, and was thoroughly enjoyed by those present.

The second paper of the evening was by Doctor Lipsett, who discussed *The Newer Conceptions of Menstrual Disorders*. The paper brought forth a great many questions, which were ably answered by Doctor Lipsett. Lantern slides were used to amplify the talk.

The regular business was transacted by the secretary, and the meeting was adjourned at 9:30 o'clock.

KARL F. WEISS, *Secretary*.



VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Tuesday, March 9.

Members present were: Doctors Rey, Cruden, Little Armitstead, Welsh, Hendricks, Yoakum, Neilsen, Strong, Mosher, D. G. Clark, W. S. Clark, Gronhoyd, L. P. Smolt, C. A. Smolt, Shore, Coffey, Bardill, Barker, and Morrison.

Guests present were: Doctors Voorsanger, Moore, Witten, Walker, Wells, Arnold, and Coulter. Mrs. Coulter, Mr. Higbee, and twelve public health nurses were also present.

Doctor Voorsanger spoke about the prevention of tuberculosis, and also outlined treatment for active cases. Discussion was opened by Dr. Charles Smolt. Doctor Little asked if there was any method available to enforce isolation against the patient's wishes. Mr. Higbee stated that in a case of a minor he could be isolated by getting an order through the juvenile court.

Dr. D. G. Clark made a motion that this Society endorse the skin-testing campaign among school children which is sponsored by the local Tuberculosis Association. Doctor Gronhoyd seconded the motion, and it was unanimously carried.

Doctor Shore was called away and no further action was taken in regard to an ethical advertising campaign.

A. A. MORRISON, *Secretary*.

CHANGES IN MEMBERSHIP

New Members (79)

Alameda County.—L. I. Oppenheimer.

Contra Costa County.—Harry E. Peters.

Kern County.—Max D. Hendricks.

Lassen-Plumas-Modoc County.—Wilbur C. Batson.

Los Angeles County.—Howard H. Allen, Kenneth W. Blake, Elena Boder, Clifton H. Briggs, Joseph Brill, William Edward Brown, Alonzo B. Cass, Charles R. Castlen, Robert F. Collins, Walter H. Drane, John Paul Ewing, Louis K. Guggenheim, Joseph Jellen, Arnold Henry Kegel, Russell W. Lyster, Allen I. Mann, Abraham Metzner, George Nador, Charles C. P. Prince, John F. Renshaw, Charles F. Row, Werner Salomon, Robert L. Sands, I. E. Sauber, Victor E. Stark, Walter L. Stilson, Solomon Strouse, Clinton H. Thienes, Emmett LeRoy Schield, Hobart P. Shattuck, Walter T. Sheets, H. Dale Wheeler, William G. Winter, Robert G. Wirth.

Mendocino-Lake County.—M. Clemens Beil.

Napa County.—Kristine B. Johnstone.

Orange County.—J. B. Price, Arthur Donaldson.

Riverside County.—Everett J. Garrison, Iner Sheld Ritchie.

San Bernardino County.—Theophilus Fleming Ford, Thomas F. Judefind, Norris B. Lawrence, Claude A. Macdonald, William A. Richardson.

San Diego County.—Russell T. Bothe, W. R. Herbert, Wilton M. Lewis, J. T. Lipe, G. L. McClintock, Dayrel D. Smith, Erwin L. Young.

San Francisco County.—Charles Wentworth Barnett, Clarence B. Cowan, Gerald Francis Doyle, Delbert Wilfred Hand, George J. Heppner, John E. Kistler, Louis C. Nuyens, Wilfred Larch Olsen, Andrew Benton Stockton, John R. Upton.

San Joaquin County.—K. M. Hidy, Edgar Shepard Leavenworth, William G. Patton, Oliver Riggle, Thornton C. Russell, Paul R. Shumaker.

San Luis Obispo County.—Thomas Ruffin Pratt, Edward Charles Sherman, Jr.

Santa Clara County.—Ben L. Bryant, E. D. Kilbourne, Karl F. Pelka, Ruth Tangier Smith.

Yuba-Sutter County.—Romayne B. Whitney.

Transferred (8)

A. D. Butterfield, from San Diego County to San Bernardino County.

Clarence E. Dixon, from San Bernardino County to Los Angeles County.

G. A. Frost, from Lassen-Plumas-Modoc County to Butte County.

W. E. Macpherson, from San Bernardino County to Los Angeles County.

William A. Rowell, from Contra Costa County to Shasta County.

Francis B. Sheldon, from San Joaquin County to Orange County.

T. K. Trick, from Los Angeles County to San Joaquin County.

Thomas A. Wong, from San Francisco County to Los Angeles County.

Resigned (6)

Coleman A. Block, from San Francisco County.

Elmina F. Cook, from Los Angeles County.

Paul F. Guernsey, from Los Angeles County.

Clelia D. Mosher, from Santa Clara County.

R. Esmond Smith, from Los Angeles County.

Oscar Tobrinier, from San Francisco County.

In Memoriam

Beck, John Edwin. Died at Tulare, April 9, 1937, age 64. Graduate of the College of Physicians and Surgeons of San Francisco, 1905. Licensed in California the same year. Doctor Beck was a member of the Tulare County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Downs, Alfred Jonathan. Died at Los Angeles, March 12, 1937, age 60. Graduate of the Jefferson Medical College of Philadelphia, 1901. Licensed in California in 1902. Doctor Downs was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✦

Eddy, Irving Herbert. Died at Glendale, March 8, 1937, age 59. Graduate of the University of Illinois College of Medicine, Chicago, 1903. Licensed in California in 1930. Doctor Eddy was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✦

Jones, Charles Breckenfeld. Died at Sacramento, March 14, 1937, age 57. Graduate of the University of California Medical School, San Francisco, 1906, and licensed in California the same year. Doctor Jones was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

✦

Mabee, Melbourne. Died at Santa Ana, March 23, 1937, age 60. Graduate of Northwestern University Medical School, Chicago, 1911. Licensed in California in 1930. Doctor Mabee was a member of the Orange County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✦

Martin, James J. Died at Long Beach, March 23, 1937, age 71. Graduate of Eclectic Medical College, Cincinnati, 1898. Licensed in California in 1922. Doctor Martin was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✦

Pruett, John Floyd. Died at San Francisco, March 17, 1937, age 51. Graduate of Stanford University School of Medicine, San Francisco, 1914, and licensed in California the same year. Doctor Pruett was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✦

Smith, Harlan Lewis. Died at Sacramento, March 12, 1937, age 34. Graduate of Northwestern University Medical School, Chicago, 1931, and licensed in California the same year. Doctor Smith was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

✦

Solomon, Jacobus C. Died at Los Angeles, March 15, 1937, age 78. Graduate of the National University of Arts and Sciences Medical Department, St. Louis, 1893. Licensed in California in 1894. Doctor Solomon was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARY



Reginald Knight Smith
1869-1937

Reginald Knight Smith died at his home April 18, 1937. He practiced until the 14th—for several days having suffered intermittent distress from coronary occlusion—days and nights when he would lie down to ease the pain, and then with undiminished readiness respond to the hospital call.

He was born in Newberg, Alabama, September 22, 1869, was graduated from the College of Physicians and Surgeons of Baltimore in 1892, served as surgeon in the United States Navy where he achieved the grade of lieutenant-commander during the Spanish-American War, and practiced obstetrics exclusively and continuously in San Francisco since 1905. He was our first exclusively obstetrical specialist. His early experience was in the Emanuel Sisterhood Polyclinic and the Fruit and Flower Mission, then in the Mount Zion obstetrical clinic, where he became chief in 1910. He was instructor in obstetrics in Cooper Medical College during the year 1908-1909, was president of the San Francisco County Medical Society in 1919 and of the California Academy of Medicine in 1934, and was a member of the Pacific Coast Society of Obstetrics and Gynecology and of various nonmedical organizations. He received no formal instruction in obstetrics other than the meager requirements of one of the less prominent medical schools, he did not publish, rarely spoke in society meetings, did not seek or receive recognition in international or national societies—in fact, he was to known to few (a far-scattered and discerning few) outside the broad locale of his practice.

But how he was known here! He was not without honor save away from his own land. For sheer volume of work it would be hard to find his equal. About 15,000 to 20,000 persons came to light by his personal aid. Two corporations of interest and profit to the local medical profession weathered through exceedingly rough seas to snug harbor under his forceful and generous leadership; two or three hospitals benefited largely from his efforts; for many years the business of the San Francisco County Medical Society drew heavily on his time and energy. And for quality, his professional work brought him early and always held, unsought but well-earned, the unquestioned title of dean of northern California obstetricians.

But work was not all that made him well known. In fact, it was much less important than character and personality. And here the pen falters. No words will quite match the feeling of us who knew "R. K." or evoke his true likeness for others. Professional ethics, courtesy, loyalty, generosity—the common book virtues? These and others would seem colorless terms to the many who have felt his helping hand, a hand deftly concealed, often escaping recognition from the one it served. Interest in the economic and other general relations of the profession to the public? Oh yes, he was tolerant, even helpful to certain schemes for bringing better medicine to more people; but we think of him as the doer rather than the schemer; we see the clinic patient whom he hastily carried in his arms to hospital;

we hear the never-failing ring of welcome in his voice to the long procession of free and near-free patients in clinics and in his office. Sense of duty, seriousness, even sternness were present, but not for exhibition; they were for principles rather than persons, and the rare individual who incurred his animosity abundantly merited it. And equanimity. That was in perfect measure and of unique variety. It could instantly settle the nerves of a fearful, suffering woman or stiffen the courage of an inexperienced doctor. Without levity, anecdote, or even mirth, it was decidedly gay. The vacationless doctor spent his whole life on one grand lark. Tall, upright carriage, firm gait, happy timbre of voice, big pink carnation, a newly bought and soon-to-be read volume of fine literature under the arm—these gave the air of being off for a jolly good time. Trouble seemed merely to raise the carnation a little higher on his breast. Or when trouble came in the operating room—one of those moments which usually calls for wiping the surgeon's brow, or sometimes (let us blush) a burst of profanity—his humming of "Swanee River" would merely become a little more sprightly. The gay equanimity endured—"I've got a through ticket," were his cheerily spoken words at the end—and will endure in the happy memory of our "R. K."

EUGENE S. KILGORE, M. D.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

News Letter

Dear Auxiliary Members:

You will be very happy to know that in the recent McReynolds *Hygeia* subscription contest the Western States division of twelve states, under the direction of Mrs. Mark Glaser, won a very high percentage. Arizona carried off the \$50 prize in Group 1 for auxiliaries with a membership not exceeding fifty members. The winning chairman is Mrs. Charles Swackhamer of Superior, Arizona, who represented Pinal County.

In the twelve counties in the entire United States given highest honorable mention, six of these counties, or 50 per cent, are in Mrs. Glaser's division, and Marin County, in California, has the distinction of being in that group.

Mrs. Glaser has done remarkable work, and we all feel very proud and honored by her achievement. We feel she richly deserves the success that has come to her, and we all tender her our hearty congratulations.

MRS. ROBERT M. FURLONG, *Chairman of Publicity.*

Component Auxiliaries

Alameda County

On March 19 the Woman's Auxiliary to the Alameda Medical Association held their annual bridge tea at the Hotel Leamington in Oakland. The spacious clubroom was beautifully decorated with spring blossoms. Two hundred and fifty members and guests gathered for the occasion, and were greeted by our president, Mrs. Clarence Page, and Mrs. Harold Trimble, Chairman of Arrangements.

During the afternoon a radio was raffled and candy sold at the tables. Over \$200 was made for the Students' Loan Fund of Stanford and California universities, which the Auxiliary is sustaining.

Before the close of the afternoon a brief business meeting was held. Mrs. Page thanked Mrs. Trimble and her committee for their work in making the party a success. The

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Robert M. Furlong, Chairman of the Publicity and Publications Committee, Linden Lane, San Rafael. Brief reports of county auxiliary meetings will be welcomed by Mrs. Furlong and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue for Woman's Auxiliary notes.

Nominating Committee for the ensuing year was announced, namely, Mesdames Hobart, Rogers, Charles Peters, D. E. Jeffry, and John Ewer.

Tea was then served, and the party adjourned after a most enjoyable and successful afternoon.

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Los Angeles County

The Woman's Auxiliary to the Los Angeles County Medical Association honored its new advisers at the regular luncheon meeting at the County Medical Building on Tuesday, March 23. These advisers are Doctors John P. Nuttall, E. Eric Larsen, and E. Vincent Askey.

Current Problems in Medical Legislation was the subject of an address by Dr. Edmund T. Remmen of Glendale, member of the Board of Directors of the Public Health League.

Mrs. E. M. Lazard, President of the Los Angeles League of Women Voters, discussed *Better Schools in Los Angeles for Handicapped Children*.

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Marin County

The Woman's Auxiliary to the Marin County Medical Society met in conjunction with the Marin County Public Health League on Thursday evening, March 25, at a dinner meeting at the Marin Golf and Country Club.

The combined groups were addressed by Dr. Glenn Cushman of San Francisco on pending medical legislation. Following Dr. Cushman's address, Dr. F. O. Butler, medical director of the State Home at Sonoma, was introduced by Mrs. H. O. Hund, President of the Woman's Auxiliary, who had secured Doctor Butler as their speaker of the evening. His subject was *The Exceptional Child*, and he gave a very interesting discussion of conditions in the institution.

Plans are now being made for a card party to be given by the Auxiliary on Friday, April 23, at the Improvement Club in San Rafael. Mrs. Robert M. Furlong is in charge of arrangements.

Our February meeting was held in the form of a luncheon at the Meadow Club. We had as special guests, Mrs. Andrew J. Thornton and Mrs. Willard Newman, both of San Diego. Twenty-seven of our thirty-two members were present and, although it was a rainy day, it was a most enjoyable one. A musical program was presented by Mr. Clinton Lewis and his octet from the Marin Junior College.

BURDELLA M. ROBERTSON,
County Chairman of Publicity.

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Sacramento County

The regular meeting of the Sacramento Auxiliary met on February 16 at the home of Mrs. Charles Van Geldren. Mrs. Knell gave a report on our Sacramento Hospital Circulating Library. The Sacramento postmaster is granting us all the new unclaimed magazines, which gives us the latest ones for the patients.

Our state president, Mrs. Thornton, and her secretary, Mrs. Newman, were our guests and gave most interesting talks on their visits to the various auxiliaries.

Our president, Mrs. Brown, thanked all who worked on the Red Cross drive.

Refreshments were served by our hostesses.

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The regular meeting of the Sacramento Auxiliary met on March 18 at the home of Mrs. Anthony Boscoe.

Reports were given by the outgoing officers.

New officers elected were: Mrs. William J. Van Den Berg, president; Mrs. Norris R. Jones, first vice-president; Mrs. Frank McDonald, second vice-president; Mrs. Dave Dozier, recording secretary; Mrs. Heldwig Johnson, corresponding secretary; Mrs. F. N. Scatena, treasurer; Mrs. Frank Knell, Mrs. Richard Scofield, Mrs. James Yovt, and Mrs. Orrin Cook, directors.

After an interesting reading by Mrs. A. Howe, we were served refreshments by our hostess.

MRS. JOHN D. LAWSON, *Corresponding Secretary.*

Santa Barbara County

The members of the Woman's Auxiliary to the Santa Barbara County Medical Society gathered at luncheon Monday, March 15, at the home of Mrs. W. H. Johnston, 205 East Islay Street, to hear a talk on *Cancer Control* by Dr. Henry J. Ullmann, a member of the Cancer Committee of the California Medical Association. Doctor Ullmann pointed out that tuberculosis, which used to rank first as a cause of mortality in the United States thirty years ago, now ranks sixth. The enormous decrease in the proportion of deaths caused by this disease is due to the splendid educational campaign carried on against it. The place of deaths from cancer in the list has changed from sixth to second in the same period of time. In other words, cancer is increasing, and a vigorous campaign is needed to educate the public to fight this much misunderstood disease intelligently. Cancer is curable, and practically all cancer has a curable stage. According to the statistics gathered at the Massachusetts "Cured Cancer Clinic," thirty thousand persons could be cured annually of this disease in the United States. Cancer cannot be stamped out as can an infectious disease, such as tuberculosis or diphtheria, but many persons can be cured of it if education can remove the fear which has, and is still, keeping them from seeking treatment early. The New York City Cancer Committee has put on an extensive and well-planned campaign. Their emblem is a shining silver sword painted upon a black background above the red slogan, "Fight Cancer with Knowledge." Free advertising space has been given them by many magazines, outdoor advertising firms, trolley, subway, and railway systems. This committee publishes a *Quarterly Review*, which describes their education campaign.

Following Doctor Ullmann's talk, Doris White read the essay which won her the first prize of \$20 in the High School class in the contest recently sponsored by the Auxiliary. In it she pointed out the immense benefits to the human race brought about through immunization against such diseases as smallpox, rabies, and diphtheria.

Mme. Marie Jankay then delighted the group with her rendition of two piano numbers—*Le Coucou* by Daquin, and *Invitation to the Dance* by Weber-Taussig.

At the business meeting which followed, a nominating committee, consisting of Mesdames Harold Schwalenburg (chairman), John Van Paing, C. T. Roome, Horace Pierce, and H. E. Henderson, was appointed.

Mrs. C. Z. Nicholas, *Hygeia* chairman, reported on a very extensive campaign which had netted the Auxiliary twenty-four new subscriptions and eleven renewals. She read a letter from the national *Hygeia* chairman, congratulating her for her efforts.

As it was a very rainy day, only sixteen members were in attendance.

MRS. H. E. HENDERSON.

*Santa Clara County*

The regular meeting of the Woman's Auxiliary to the Santa Clara County Medical Association was held at the St. Claire Hotel on April 5 at luncheon, thirty-one members being present.

Dr. R. S. Kneeshaw, president of the County Medical Association, was guest speaker. His subject was *Medical Legislative Problems*.

Mrs. John Hunt Shephard, convention chairman, discussed convention plans, and named those who are to serve on committees.

It was voted to present a scholarship to the Y. W. C. A. for the girls summer camp at Big Basin. Last year 146 girls enjoyed a two weeks' vacation, seventy-one of which were scholarship recipients.

The officers for next year were voted upon and will be announced at Del Monte in May.

MRS. DANIEL BILKER,
Press and Publicity Chairman.

Tuberculosis in Young Adults.—Lloyd and Macpherson stress the fact that about four out of every five young adults suffering from pulmonary tuberculosis who have been in contact with a known case of infection develop the disease within five years of exposure to the last known

contact. This demonstrates the value of continuing the observation of contacts for at least five years after they were known to be last exposed. There is a history of household infection in 82 per cent of the contact cases. History of exposure to tuberculous fathers is almost twice as frequent as history of exposure to tuberculous mothers. In about half of the contact cases, spread of infection is not obviously due to transmission of the disease from parent to offspring, but in many cases infection is apparently introduced into the household by a brother or sister. About 60 per cent of the young adults who develop pulmonary tuberculosis are unaware of any contact with the infection. In noncontact cases the toxemic type of onset is more common than the nontoxemic (70 versus 28 per cent). If all classes of contact cases are taken together, the toxemic and nontoxemic types of onset occur in about equal proportions. It appears, however, that, if there is an interval of more than five years between the last known exposure to infection and the onset of the disease, the onset is more likely to be of the nontoxemic type.—*British Medical Journal*.

Automobile Trailer Sanitation.—As trailers multiply on our roads, new sanitary problems arise to disturb our health officials. Foremost are the provision of safe milk and water and the sanitary disposal of human waste.¹ With reasonable care in choice, safe water is readily available along the highways in many states; similarly the obtaining of safe milk, while slightly more difficult offers no great hazard to the careful purchaser. The chief source of concern is the unsafe or insanitary disposal of human excreta by trailer travelers. Many trailers now provide a small toilet compartment in which excreta may be deposited in cans containing chemical solutions reputed to render the waste innocuous. What to do with the material in the cans is the problem of present concern. No extensive or satisfactory sanitary provisions have been made for the disposal of these wastes and the cleansing of the cans. Serious consideration, it is believed, must now be given to providing roadside facilities for the sanitary disposal of human waste from auto trailers. State or county departments of health may construct disposal systems near roads frequented by auto trailers, the location of which can be made known by appropriate road signs. Recognition has been recently accorded the problem by the city and county of San Francisco,² which has prepared a sanitary code suggested for their citizens when using such conveyances for traveling. According to this code, all trailers should be equipped with an air-tight container of not less than five gallons capacity for the storage of garbage. This container may be emptied only in places approved and so designated by the health authorities of a particular locality. If the trailer is equipped with running water and a flush toilet, an adequate sewage tank should be provided underneath the trailer for the collection and storage of such waste. The tank should be emptied only into sewer connections or by other approved methods of disposal provided by the community. When equipped with water tanks for household use, the tanks must be inspected by an approved health authority at intervals of six months with reference to the potability of the water. Furthermore, water for filling the tanks should be drawn only from certified sources. The code also imposes regulations concerned with parking, food supply, ventilation, cleanliness, and screening. The use of pasteurized milk exclusively is recommended, and trailer travelers are warned concerning the need for securing medical attention if illness arises. The desirability of vaccination of children against smallpox and their inoculation against diphtheria is stressed. Even if no further increase in the number of individuals traveling and living in automobile trailers should occur, it is definitely incumbent on local health authorities to enact and enforce suitable legislation covering the health problems raised by this migratory population.—*Journal A. M. A.*

¹ A New Problem in Sanitation. Pub. Health Rep., 51:1791 (Dec. 25), 1936.

² Geiger, J. C.: Sanitary Code for Automobile Trailers, City and County of San Francisco, personal communication.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 7-11. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Del Monte, May 3-6. F. C. Warnshuis, M. D., 450 Sutter Street, San Francisco, Secretary.

American Heart Association, Atlantic City, New Jersey, June 7-8.

American Surgical Association, New York, June 3-5. Charles G. Mixter, M. D., 319 Longwood Avenue, Boston, Secretary.

State Medical Association of Texas, Fort Worth, May 10-13. Holman Taylor, M. D., 1404 West El Paso Street, Fort Worth, Secretary.

Medical Broadcasts*

The American Medical Association and the National Broadcasting Company are presenting the second series of dramatized health broadcasts, under the title, "Your Health." The first broadcast in the new series, the thirty-second dramatized cooperative broadcast under the title "Your Health," was given October 13, 1936. The theme for 1936-1937 differs slightly from the topic in the first series, which was "Medical Emergencies and How They Are Met." The new series is built around the central idea that "one hundred thousand American physicians in great cities and tiny villages, who are members of the American Medical Association and of county and state medical societies, stand ready, day and night, to serve the American people in sickness and in health."

The program will be on the Blue network

The time of the broadcast is Tuesday afternoon, one o'clock, Pacific time.

The topics are announced monthly in advance in *Hygeia*, the health magazine, and three weeks in advance in each issue of the *Journal of the American Medical Association*.

San Francisco County Medical Society

A radio broadcast program for the San Francisco County Medical Society for the month of May is as follows:

Tuesday, May 4—KYA, 6 p. m.

Tuesday, May 11—KYA, 6 p. m.

Tuesday, May 18—KYA, 6 p. m.

Tuesday, May 25—KYA, 6 p. m.

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of May is as follows:

Saturday, May 1—KFI, 9:15 a. m., The Road to Health.

Saturday, May 1—KFAC, 10:15 a. m., Your Doctor and You.

Thursday, May 6—KECA, 10:45 a. m., The Road to Health.

Saturday, May 8—KFI, 9:15 a. m., The Road to Health.

Saturday, May 8—KFAC, 10:15 a. m., Your Doctor and You.

Thursday, May 13—KECA, 10:45 a. m., The Road to Health.

Saturday, May 15—KFI, 9:15 a. m., The Road to Health.

Saturday, May 15—KFAC, 10:15 a. m., Your Doctor and You.

Thursday, May 20—KECA, 10:45 a. m., The Road to Health.

Saturday, May 22—KFI, 9:15 a. m., The Road to Health.

Saturday, May 22—KFAC, 10:15 a. m., Your Doctor and You.

Thursday, May 27—KECA, 10:45 a. m., The Road to Health.

Saturday, May 29—KFI, 9:15 a. m., The Road to Health.

Saturday, May 29—KFAC, 10:15 a. m., Your Doctor and You.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

American Association for the Study of Goiter.—The annual meeting of the American Association for the Study of Goiter will be held in Detroit, Michigan, June 14-16, with headquarters at the Book-Cadillac Hotel. Copies of the tentative program may be secured by request to W. Blair Mosser, M. D., Corresponding Secretary, Kane, Pennsylvania.

Better Knowledge of Cesarean Section Needed.—Maternal mortality in the United States is still unduly high and the incidence of cesarean delivery has not lowered this rate, despite its increase and apparent popularity. This is stated by Dr. F. W. Lynch, professor of obstetrics and gynecology in the University of California Medical School, who contends that because of reasons for which the public itself is largely responsible, cesarean section is being performed far too frequently "in the face of indications which experience has shown entail an unjustifiably high maternal mortality."

Doctor Lynch holds that such deliveries should be limited to cases in which valid reasons for their use exists. Many such operations are performed "on demand of the patient," or "for economic reasons," whereas, in a number of these cases another type of delivery should be employed, he said.

Mortality from surgical intervention is becoming less and less in other gynecologic cases, he said. "The increase in cesarean mortality has been initiated by both the laity and the profession."

Doctor Lynch gave a number of maternal mortality figures embraced in the histories of 524,117 women taken over a period of years, and the part that cesarean delivery played in this mortality. His findings are published in the current issue of *Surgery, Gynecology and Obstetrics*, and were presented at the annual meeting of the American College of Surgeons in Philadelphia.

Milbank Memorial Fund.—The Milbank Memorial Fund, 40 Wall Street, New York, gave \$321,518.13 in 1936 for projects and grants-in-aid in the fields of public health, medicine, population, education, and social welfare, according to the annual report of the Fund, published today. This brings to a total of \$11,067,517.07 its appropriations for philanthropic purposes during the thirty-two years since its establishment in 1905 by Mrs. Elizabeth Milbank Anderson. Of this amount, approximately \$3,500,000 was given in the period of 1930-1936.

In a foreword to the report, Albert G. Milbank, President of the Fund, points out that during this depression period "it has become evident that the conception of public health must not be restricted to its former limits, but must broaden out beyond the scope of preventive medicine to advance further and further into the field of social protection in the largest sense of the word. The successful application of corrective and preventive public health activities frequently rests upon the concurrent solution of many other problems, for example, poor housing, nutrition, population trends and their influences on the future economic and social life of the country—which formerly did not seem to have any close or intimate connection with public health. There is no single avenue of approach by which the goal of health and happiness for all of the people can be gained. Rather, its achievement will depend upon the concerted attack of the workers in many fields of social endeavor—medicine, public health, welfare and relief, education, and research."

In 1936, the Fund assisted organizations in all of these fields, although its principal contributions, both in financial support and technical assistance, were made in the field of public health. . . .

Health Section of Los Angeles City Schools.—In the belief that correction of recurring defects is not sufficient and that health education is the most important function of a school health department, the Health Service Section of the Los Angeles City Schools, under the direction of Dr. Sven Lokrantz, has established a Health Education Unit.

This unit has as its purpose the education of school children, parents, teachers, and general public in health matters. The methods used are: lectures to Parent-Teachers Association and student groups, the use of health materials in curricula, the showing of health films and slides in schools, bulletins to teachers and parents, and radio talks to the public.

Specifically, the department is issuing to teachers and all those interested in public health matters, a mimeographed bimonthly publication called "Health News." Beginning Thursday, April 29, and continuing Thursday thereafter, a ten-minute radio health lecture will be given over KECA at 6:15 p.m. These broadcasts will be given by physicians in the health department and by other physicians interested in public-health matters. These lectures are to be passed on by the Los Angeles County Medical Association.

Last Rites for Dr. R. K. Smith.—The San Francisco *Call-Bulletin* of April 20, 1937, printed the following item:

Funeral services were held today for Dr. Reginald Knight Smith, dean of San Francisco obstetricians.

During his thirty-two years of practice in San Francisco, Doctor Smith attained eminence as a child specialist and obstetrician.

Doctor Smith is survived by his widow, Mrs. Alice Scott Smith; two children, Irving M. S. Smith and Miss Betty Knight Smith, and a brother, Dr. Wallace Smith of San Francisco.

Following the services at Grace Cathedral, interment was at Cypress Lawn.

Honorary pallbearers were: Drs. Herbert C. Moffitt, Wallace I. Terry, Arthur L. Bloomfield, Ernest S. DuBray, R. Langley Porter, Thomas H. O'Connor, John H. Graves, Walter B. Coffey, Harry E. Alderson, Howard C. Naffziger, Loren R. Chandler, Ludwig Emge, Frank W. Lynch, Harold Brunn, William C. Voorsanger, William P. Lucas, Irving S. Ingber, Guy S. Millberry, Karl L. Schaupt, Henry A. Stephenson, Paul E. Hoffman, Stanley Mentzer, T. Henshaw Kelly, Cavins D. Hart, Captain H. B. Price, John Francis Neylan, and Mr. Hartley F. Peart.

Statement on American Medicine.—A survey of the present status of American medical practice, which some might regard as exceedingly frank, has just been released locally by the American Foundation of New York through the University of California Medical School and other sources. The survey was intended to get to the bottom of the problem of making adequate medical care available to the large part of the population that now fails to get it.

All of the information obtained in the survey was gathered and submitted by the doctors themselves, most of them having twenty or more years' experience. The Foundation merely asked the doctors for a statement of existing facts and from these it made up a report graphically presenting the picture of American medicine as it functions at the present time. No conclusions or recommendations are contained in the report, as it was intended as a plain statement of fact and nothing more.

Arguments both for and against the establishment of a Department of Public Health in the United States Government, with its own Cabinet member, and such issues as "Is there too much surgery?" "Is there too much specialization?" and "Is the Family Doctor passing?" feature the report. Some doctors hold that there are too many poor and too few good specialists, and many hospitals have expensive and unnecessary "frills." One group contends that everyone should be compelled to save some money for medical care.

The Foundation Committee directing the survey contains such personages as Curtis Bok (chairman), Thomas W. Lamont, Robert A. Millikan, Roscoe Pound, Mrs. Ogden Reid, Mrs. F. A. Vanderlip, and John G. Winant.

Concerning Examination of Eyes of School Children. The following resolution was adopted by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association in February, 1937:

WHEREAS, The eyes and the sight of the school child are of the most vital importance for satisfactory school work, and their preservation for future health and efficiency depends upon their wise conservation during childhood; and

WHEREAS, The school has a grave responsibility for the conservation of eyesight among school children; and

WHEREAS, School administrators in many parts of the United States are frequently besieged with demands for admission into their school systems of eye examinations and eye-glass prescriptions by practitioners other than qualified doctors of medicine; and

WHEREAS, The eye, as an organ of vital necessity, requires careful conservation and deserves treatment only at the hands of trained and competent persons; and

WHEREAS, Teachers and nurses properly may and often do make rough tests of visual acuity in the classroom, but diagnosis of diseases of the eye and of disturbances of vision requires more extensive examination and often involves treatment other than the mere fitting of glasses; and

WHEREAS, Even the fitting of glasses often requires the paralysis of accommodation through the use of drugs popularly known as "drops"; now, therefore, be it

Resolved, That it is the sense of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, in meeting assembled at New Orleans, February 23, 1937, that the safety of the eyes of school children, the adequate diagnosis of disease and the correct fitting of glasses require examination of children's eyes (beyond rough visual tests performed by teachers or nurses) by a licensed doctor of medicine and, upon his recommendation, by a medical specialist in diseases of the eye, properly known as an oculist or ophthalmologist.

Experimental Tunnel at Mount Weather, Virginia.—A research tunnel, or adit, for testing purposes has been established by the United States Bureau of Mines, Department of the Interior, on the Government Reservation at Mount Weather, Virginia, under a cooperative arrangement with the Weather Bureau and the Department of Agriculture. This site was selected as being the most desirable among many considered because it is on Government-owned land and because the prevailing rock is especially suitable for conducting drilling tests.

The object of the research at Mount Weather is to increase the knowledge of the details of the various steps in metal mining and to improve the underground working conditions affecting the health of miners. Similar work for coal mines is being done by the Bureau of Mines at its experimental coal mine at Bruceton, Pennsylvania, near Pittsburgh, where especial emphasis is placed on the study of prevention of coal-dust explosions.

The problems on the current program at Mount Weather include technical investigations of rock drilling; tests to establish the comparative efficiencies of rock drill bits fabricated from different steel alloys and from carbon steel; studies of the formation and prevention of dust caused by blasting, rock drilling, loading of mine cars and underground transportation; research in blasting, including the depth and method of placing drill holes for the best results in breaking ground; gases formed by different kinds of explosives after blasting; ventilation of underground mine openings; and other related subjects.

The project is an activity of the Mining Division of the Bureau, and the operations are in direct charge of Wing G. Agnew, as resident engineer. Normally, work is confined to the day shift by a small force of regular workmen. Occasional assistance in clearing the grounds and surfacing roadways has been given by members of the Civilian Conservation Corps from the near-by camp at Front Royal. When tests are being conducted at the tunnel, specialists from the several divisions of the Bureau of Mines cooperate in a common endeavor to solve the particular problem under investigation.

Upon the completion of a series of tests, the results will be published by the Bureau of Mines and will be available to all those who may be interested.

Quarantine Order, Dogs and Cats: Long Beach.

An investigation having been made as required in Chapter 369, Statutes of 1913, of the State of California, and rabies having been found to exist among dogs living within the city of Long Beach, the California State Board of Public Health hereby declares a quarantine against all dogs and cats within those city boundaries of Long Beach as described in the charter of the city of Long Beach amended as of 1933.

Quarantine under this Act means the strict confinement, upon the private premises of the owners under restraint by leash or closed cage or paddock, of all dogs and cats within the above described area.

It shall be the duty of all peace officers, the City Veterinarian and all deputies of the City Health Officer, as well as the City Health Officer, to enforce the provisions of this order within the above quarantined area.

The City Health Officer, or other properly constituted officials, may make inspection or examination and enter upon all private premises for the enforcement of this quarantine.

Any owner, or other person in possession of any animal being held or maintained in violation of this quarantine, shall be subject to arrest on the charge of committing a misdemeanor.

Southern California Medical Association.—This Association held its ninety-sixth semi-annual meeting on April 9 and 10 at the Hotel Del Coronado, Coronado, under the direction of its Committee on Arrangements: Doctors L. H. Redelings, Ray C. Loundsberry, Robert E. Austin, Mrs. C. O. Tanner (Women's Entertainment), and officers—Doctors Merrill W. Hollingsworth, President, Santa Ana; LeRoy Sherry, First Vice-President, Pasadena; C. L. Emmons, Second Vice-President, Ontario; Robert W. Langley, Acting Secretary, Los Angeles.

The program follows:

FRIDAY AFTERNOON SESSION

Contact Eczema—Joseph Weinberger, M. D., San Diego. Discussion by Hiram Newton, M. D., San Diego, and H. P. Jacobson, M. D., Los Angeles.

The Treatment of Acute Cholecystitis—H. P. Totten, M. D., Los Angeles. Discussion by Chester Tanner, M. D., San Diego, and J. Norman O'Neill, M. D., Los Angeles.

The Facts About Radium and X-Ray Therapy—George S. Sharp, M. D., Pasadena. Discussion by C. Hiram Weaver, M. D., Los Angeles, and Douglas R. MacColl, M. D., Los Angeles.

Experimentally Induced Variations in Plasma CO₂ Combining Power—Noel F. Shambaugh, M. D., Los Angeles. Discussion by Dr. Henry Borsook, California Institute of Technology, Pasadena.

FRIDAY EVENING SESSION

In Memory of David Ghrist—Elmert Belt, M. D., Los Angeles.

Methods of Directing the Urine Above the Level of the Bladder—Hugh Cabot, M. D., Section on Urology, Mayo Clinic, Rochester.

SATURDAY MORNING SESSION

Osteomyelitis in the Newborn—Russell T. Bothe, M. D., San Diego. Discussion by William W. Belford, M. D., San Diego, and Joseph J. O'Hara, M. D., San Diego.

The Practical Application of Skin Tests in Dermatology—William H. Goeckerman, M. D., Los Angeles. Discussion by Dr. L. F. X. Wilhelm, Los Angeles, and Dr. Philip K. Allen, San Diego.

Typhus Fever in San Diego County—Arthur A. Marlow, M. D., San Diego. Discussion by Dr. E. Minton Fetter, San Diego.

The Cancer Problem in the United States Navy—Lieutenant Commander O. B. Spalding (MC), United States Navy. Discussion by Albert Soiland, M. D., Los Angeles, and Albert E. McEvers, M. D., Los Angeles.

SATURDAY AFTERNOON SESSION

A Résumé of Protozoan Infestation in Southern California as Shown by Records in a Large General Hospital,

Over the Latest Decades—John V. Barrow, M. D., Los Angeles. Discussion by William C. Boeck, M. D., Los Angeles, and Fred B. Clarke, M. D., Long Beach.

An Estimate of Mapharsen in Early Syphilis—Commander R. P. Parson (MC), United States Navy. Discussion by Samuel Ayres, M. D., Los Angeles, and Julius R. Scholtz, M. D., Los Angeles.

Heat Production and Heat Loss in Chills and Fever—Eugene F. DuBois, M. D., Professor of Medicine at Cornell Medical College, and Medical Director of the Russell Sage Institute, New York City.

The Board of Governors for 1936-1937 includes: Doctors F. M. Pottenger, Egerton Crispin, Joseph King, Charles T. Sturgeon, Raymond G. Taylor, Carl R. Howson, all of Los Angeles; Rexwald Brown, Santa Barbara; Joseph K. Swindt, Pomona; Paul E. Simmonds, Riverside; Fred B. Clarke, Long Beach.

The Councilors are: Doctors Bon O. Adams, Riverside; H. Douglas Eaton, Los Angeles; Franklin Nuzum, Santa Barbara; Robert W. Langley, ex officio; and David Ghrist, ex officio.

Clinical Problems in Syphilis Control Today.—John H. Stokes, Philadelphia (*Journal of the American Medical Association*, March 6, 1937), brings out the fact that the League of Nations investigation brought to the dignity of statistical demonstration the fact that clinics, widely regarded as the chief instruments for the control of syphilis, are so inefficiently run the world over that 20 per cent of their early syphilis material has not received even the minimum of darkfield examination and serologic testing required by the past two decades of knowledge of the disease. Two adequate systems for the treatment of early syphilis can now be issued in black and white for public health and voluntary agents, including private physicians' reference and use: the British-Danish intermittent and the American continuous alternating. Of the two the Coöperative Clinical Group and the United States Public Health Service believe they have proved the alternating continuous treatment to be the better. With new detection machinery in full movement, an enormous influx of seropositive latency is to be expected and must be evaluated and treated. Hospital, and outpatient and practitioner "pick ups" require (1) adequate complete physical examination, not mere listening through the shirt and tapping the knees; (2) with a negative physical examination the beginning of treatment, not by the first arsenical "shot" one can reach, but with bismuth subsalicylate weekly, while one gains the patient's confidence and a spinal-fluid examination. For two reasons the author would place the syphilitic woman first rather than fourth among the modern problems of syphilis. Infectious early syphilis of a woman's genital tract is the *terra incognita* of the public health aspect of the disease. The relatively more benign and inconspicuous course of the whole infection, which Warthin rated as in her almost a disease in a different animal species, fills the terrain with the unexpected and unpredictable and makes epidemiologic and therapeutic certainties rare indeed. As soon as possible after the recognition of prenatal syphilis, especially of the tardive type, the spinal fluid should be examined in order to forestall the onset of grave neurosyphilis by fever therapy, precisely as one does in acquired syphilis. Few rules will thwart more tragic consequences. Of the therapy of neurosyphilis, Ravaut, who brought asymptomatic neurosyphilis to light, died ten years too soon. He suggested, and would probably have shown, that a great deal of neurosyphilis recovers of itself; that even the parietic formula is compatible with a long, effective and healthy life. It is clearly proved that asymptomatic neurosyphilis tends to be withheld from symptomatic expression or cured by a prolongation plus some form of intensification of standard treatment for the disease. The incidence of asymptomatic neurosyphilis is reduced practically to zero by sufficiently intensive treatment begun early in the disease. Injections of chemotherapeutic agents are merely mediated by the hand and head. Effective treatment for syphilis may indeed be mechanized to a certain perfection by knowledge. But the uprooting of the disease from its hold on humanity is done by the eye, the voice, the understanding and sympathetic spirit, without which all the much gathering of knowledge is but the unliving dust.

New Development in Study of Spinal Disease Virus. Difference in the severity of outbreaks of poliomyelitis, an inflammation of the spinal cord, in different regions may be accounted for by a qualitative difference between different strains of the virus causing this disease.

This conclusion was pointed to by recent experiments carried on at the Hooper Foundation for Medical Research of the University of California. Results of the experiments were reported in *Science* magazine by B. F. Howitt, associate in research medicine at the University.

According to the *Science* article, the mildness of outbreaks in some sections as compared with the severity of outbreaks in other localities may be explained by regional differences in the strains of virus. This difference may be explained not only by a variance in infectiousness or potency of the virus, but also in the tendency to build up immunity.

Undoubtedly, says the author, the high immunity of certain communities accounts for the comparatively low number of cases recorded. Yet sudden outbreaks of poliomyelitis do occur which are accompanied by high mortality. Howitt believes that these attacks may be accounted for by the sudden introduction into such regions of a virus of different quality from that to which the population is ordinarily exposed combined with high infectiousness.

Therefore, in judging the results of serum therapy, some account must be taken of the possible differences of virulence in the virus of different regions. Populations ordinarily exposed to a mild strain of virus to which they have built up a high immunity may not be able to resist one of high potency. Thus they would not respond as well to serum from those immune to the milder strain.

Virus for the experiments was obtained from a fatal case during the outbreak in Sacramento in 1934. This was compared with another strain obtained from the New York City Health Department, and with others on hand, notably one obtained from a fatal case in San Francisco.

1937 Graduate Fortnight: New York Academy of Medicine.—For the Annual Graduate Fortnight of the New York Academy of Medicine a subject of outstanding importance in the practice of medicine and surgery is selected and is presented from as many angles as possible. It offers to the profession a résumé of the present knowledge of the subject so that the practitioner may be so informed.

The Tenth Annual Graduate Fortnight will be held November 1 to 12, and will be devoted to a consideration of medical and surgical disorders of the urinary tract. The subject will include Bright's disease, arterial hypertension, and infections, tumors, calculi and obstructions of the urinary tract, and will exclude venereal disease, diseases of the genitalia, and gynecology.

Twenty important hospitals of the city will present coordinated morning and afternoon clinics and clinical demonstrations. At the evening meetings, prominent clinicians of New York and many of the other leading medical centers of this country who are recognized authorities in their special fields will discuss the several aspects of the general subject.

A comprehensive exhibit of books, pathologic and research material, diagnosis, treatment and prevention whenever possible, clinical and laboratory diagnostic methods, x-rays, action of drugs and other therapeutic measures. Demonstrations will be held at regular intervals.

Some of the features to be presented at the meetings, in the clinics and in the exhibit will be:

- Physiology of the kidney.
- Tests for kidney function.
- Edema and its treatment.
- Uremia and pathology of kidney function.
- Pathology of nephritis.
- Clinical aspects of nephritis including glomerular, focal, embolic and acute interstitial nephritis.
- Nature of hypertension.
- Clinical aspects of hypertension, including malignant hypertension.
- Evaluation of the surgical treatment of hypertension.
- The nephroses.
- Vascular and renal complications of pregnancy.
- The relation of psychogenic factors of hypertension.

Pathogenesis and treatment of renal infections.

Renal and perirenal infections.

Tuberculosis of the kidney.

Calculus disease. The formation of stones.

Clinical aspects of calculus disease.

Hydronephrosis and pyonephrosis.

Bright's disease in children.

Common urologic diseases in children.

Radiotherapy of tumors of the urinary tract.

Tumors of the kidney and ureter.

Tumors of the urinary bladder.

Pathologic physiology of bladder-neck obstructions.

Transurethral resection of bladder-neck obstructions.

Surgical treatment of obstructions at the neck of the bladder.

The medical profession is invited to attend.

A complete program and registration blank may be secured by addressing Dr. Mahlon Ashford, The New York Academy of Medicine, 2 East 103rd Street, New York City.

Bacillus May Be Either Harmless or Villainous.—A "Dr. Jekyll and Mr. Hyde" in the tiny world of microscopic bacteria has been detected by Dr. Francis E. Clark, bacteriologist in the United States Department of Agriculture's division of soil microbiology.

As a villain the bacillus most recently was identified as *Bacillus siamensis*, a pathogenic or virulent form recovered from various pathologic sources, including contaminated human blood.

In a more common rôle it has long been known as *Bacillus cereus*—one of the most common and harmless of all soil bacteria—inhabiting the air and soil in countless millions. Other bacteriologists have noted the similarity in appearance but, because one is virulent and the other harmless, concluded there was a difference.

Before coming to the Department of Agriculture, Doctor Clark was a bacteriologist in the Colorado General Hospital. In a routine examination of a blood sample, he found the virulent *B. siamensis*. He cultured the tiny, spore-forming microbe.

After isolating *B. siamensis*, Doctor Clark cultured it for twenty-four hours on glucose broth. An injection of one cubic centimeter under the skull killed a guinea pig within a few hours. Subcultured over a longer period, the bacilli gradually lost virulence. At the end of a month it required four cubic centimeters to kill a guinea pig. After three months even this amount was not fatal.

When Doctor Clark transferred his work to the Department of Agriculture, he showed the results of his study to N. R. Smith, senior bacteriologist, who immediately noticed the striking similarity between the *B. siamensis* and *B. cereus*. Subsequent culture tests showed them to be identical.

A virulence test of *B. cereus* first bore out the common opinion of bacteriologists that the bacillus does not cause disease. However, when it was subcultured rapidly on blood agar for a few generations, the surface growth after twenty-four hours was virulent enough to kill a guinea pig overnight.

Thus, under culture, the "non-virulent" bacilli became virulent. In the same manner the virulent form lost its virulence in a typical "Dr. Jekyll and Mr. Hyde" manner.

Two significant results are seen. In the first place, medical pathologists may save time and trouble by comparing any apparently new virulent and spore-forming bacillus with *B. cereus*. In the second place, it is a step forward in avoiding a too arbitrary "break down" of bacilli into virulent and non-virulent fields, a subject with which bacteriologists have made little progress in the past.

There is small probability of any human illness from such border-line pathogens, says Doctor Clark, and they usually do not attack such laboratory animals as the guinea pig unless injected artificially in large doses. However, it is entirely possible that they may cause natural epidemics in the lower forms of animal life. An example is the identification of the *B. Cereus*—*B. siamensis* group submitted to Doctor Clark by workers in the Bureau of Entomology and Plant Quarantine. The bacilli were responsible for a highly fatal epidemic septicemia of army worms which were being used in laboratory experiments.

LETTERS

Concerning reprint of "San Francisco Chronicle" article on a Proposed Medical Service Law: Additional information and correction concerning the same.*

LEO H. SHAPIRO
Attorney at Law

San Francisco, California,
April 22, 1937.

California and Western Medicine
Room 2004, 450 Sutter Street
San Francisco California
Attention Frederick C. Warnshuis
Gentlemen:

In your issue of March, 1937, on page 212 thereof, you have published an article under the title, "Bill (Williams) Not Health Insurance," by Chester Rowell. This article purports to be a copy of an article as published by Chester Rowell in the *San Francisco Chronicle* on September 17, 1936.

The portion of the article which is particularly objectionable to me is the statement that the bill which is described in the article was drafted by me on behalf of Credit Unions. For your information, Mr. Rowell, in subsequent articles in the *San Francisco Chronicle*, after receiving the true facts in connection with the statements previously published by him, editorially retracted any statements in connection with such bill as applicable to me.

For your information, I had nothing whatever to do with the preparation of any medical or health bill. Credit Unions are interested in securing proper and adequate health insurance, to be strictly supervised and to be rendered according to the best standards of the medical profession. They are not interested in rackets of any kind or nature, and they want to see physicians duly and adequately paid, without any deductions for any promotional propositions.

I would, therefore, appreciate the correction or retraction of the article as published by you, and I would suggest that you contact Mr. Rowell in order to confirm the statements which I have made herein.

Appreciating your prompt response, I am
68 Post Street.

Yours truly,
(Signed) LEO SHAPIRO.

Concerning syphilis: A letter from a United States Fleet medical officer.

UNITED STATES FLEET
U. S. S. PENNSYLVANIA, FLAGSHIP
San Pedro, California,
March 30, 1937.

J. P. Nuttall, M. D.
President, Los Angeles County Medical Association.
Dear Doctor:

The disease syphilis is acquired by the men of the Navy during periods of leave and liberty ashore. Approximately 10 per cent of our crews have this disease. The major part of the United States Fleet bases for most of the year on two ports of Southern California, Los Angeles and San Diego. A very large proportion of new admissions for syphilis are acquired in the State of California. For this reason the renewal of interest in the control of syphilis being taken in California brings to us a ray of hope. For many years the Navy has brought early diagnosis, early segregation of the infectious and early treatment to bear upon this disease within the confines of its own environment. The increasing evidence that similar activity is now contemplated on a state-wide and perhaps a nation-wide basis is heartening indeed.

Statements which have appeared recently in the Bulletin of the Los Angeles County Medical Association relate to the pressing need for greater activity by all physicians and public health activities. Such an attack upon this disease will succeed in reducing its incidence in the population. It is most gratifying to see that the leadership of your influential society is being brought to bear upon this problem.

The 65,000 men of the Fleet, whose medical care devolves upon naval surgeons, are protected by prophylactics to only

a small degree. They, therefore, must place their hope for effective action against the physicians in the civil community.

We hope that the effort now being made in the Legislature of the State of California to write into the statutes a strong and effective legal basis for better control of syphilis will be successful. We hope that as leaders of medical action in the metropolitan center of Los Angeles your society will realize that we follow your activities in this campaign with the greatest interest. We in the Fleet stand ready to cooperate to the fullest extent with any laws or regulations civilian authority may enact to lessen the incidence of this widespread and active destroyer of human life and health.

Sincerely and hopefully yours,

(Signed) GEORGE F. COTTLE,
Captain, (M. C.) United States Navy,
Fleet Medical Officer.

Concerning California's indigent transient problem.

LOS ANGELES CHAMBER OF COMMERCE
LOS ANGELES, CALIFORNIA

April 15, 1937.

Dear Dr. Kress:

Reference is made to my letter of March 22. The fact that you have not heard from me sooner does not mean that we are not deeply interested in the indigent transient problem in California, and its solution.

Apparently, from the opinion rendered by the Attorney-General's office, there is no doubt that the entrance of those who are sick and liable to become a burden upon the community can be stopped. Indeed, the decision seems to me to go much further and recognize the right of the state to keep out those who may become a public charge on the state and county.

The Chamber has a special committee studying this whole problem. This committee would be very glad to go into this phase of the matter and, if you find time, I would very much appreciate it if you would meet with the group.

Very truly yours,

LOS ANGELES CHAMBER OF COMMERCE,
Arthur G. Arnoll,
Secretary and General Manager.

Concerning State Medical Board's interpretation of emergency medical care.

The item below, with the notation by the editor of the publication, is taken from the *Yuba City Independent-Farmer*:

Editor's Note.—The following letter from Dr. Charles B. Pinkham, Secretary-Treasurer of the Board of Medical Examiners of the State of California, is discussed in full in the editorial columns of today's *Independent-Farmer*.

San Francisco, California,
March 20, 1937.

Re Medical Practice Act.
Editor, *Independent-Farmer*
Yuba City, Sutter County, California

Dear Sir:

Permit me to correct your misrepresentation of the Medical Practice Act, as expressed in the editorial printed in the *Yuba City, California, Independent-Farmer*, March 2, 1937. Therein you claim that such procedure as applying iodine to a skinned knee or using methol or aspirin tablets for a cold, or removing a cinder from an eye, constitutes a violation of the Medical Practice Act.

May we call your attention to Section 22 of said Act, reading in part as follows:

"Nothing in this Act shall be construed to prohibit service in case of emergency or the domestic administration of family remedies."

Hence, your suggestion that a "school employee is in danger of arrest if he or she applies iodine to a scratch or puts a protective bit of gauze on a skinned knee" is a misstatement of fact.

The situation which occasioned your editorial arose because a public health school nurse was reported to have taken it upon herself to diagnose a skin disease and prescribe a remedy therefor. This is strictly prohibited under

* This letter from Attorney Shapiro is printed for the information of all concerned.—Editor.

Section 17 of the Medical Practice Act, copy of which please find enclosed. If such procedure should be permitted to laymen, including public-school nurses, not thoroughly trained in medicine, diagnosis, etc., it must be conceded that the avenue will be opened to serious epidemics, etc. Either of these groups could easily make an error in diagnosing a case of smallpox as one of scabies or some similar condition. By so doing, the case of smallpox would no doubt infect a large number of individuals, causing an epidemic.

The Board of Medical Examiners has had complaints from many sections of the State of California that public-school nurses diagnose physical conditions of school children, thereafter recommending treatment and often prescribing remedies. This is not conducive to the best interest either of the individual or the community. Instances have been reported where a case of diphtheria has been diagnosed as an ordinary sore throat and a gargle prescribed.

Trusting that you will correct the misinformation in the editorial above referred to, believe me

Very truly yours,

C. B. PINKHAM, M. D.,
Secretary-Treasurer.

The following excerpts from the Medical Practice Act were enclosed with the letter:

"Sec. 17. Any person who shall practice or attempt to practice, or who advertises or holds himself out as practicing, any system or mode or treating the sick or afflicted in this state, or who shall diagnose, treat, operate for, or prescribe for any ailment, blemish, deformity, disease, disfigurement, disorder, injury or other mental or physical condition of any person, without having at the time of so doing a valid unrevoked certificate as provided in this Act, or who shall in any sign or in any advertisement use the word 'doctor,' the letters or prefix 'Dr.,' the letters 'M. D.,' or any other term or letters indicating or implying that he is a doctor, physician and surgeon, physician, surgeon or practitioner, under the terms of this or any other act, or that he is entitled to practice hereunder, or under any other law, or who shall in any sign or any advertisement or otherwise use the word 'chiroprapist,' 'foot specialist,' or any other term or terms, or letters indicating or implying that he is a chiroprapist, or that he practices or holds himself out as practicing chiroprapy or foot correction, as defined in Section 8 of this Act, without having at the time of so doing, a valid unrevoked certificate as provided for in this Act, shall be guilty of a misdemeanor and upon conviction thereof shall be punished as designated in this Act; provided that nothing contained in this section shall be construed to prohibit the manufacture, the recommendation, or sale of either corrective shoes or of appliances for human feet." (Amended statutes 1915, page 184; statutes 1917, page 93; statutes 1929, page 435; statutes 1933, chap. 499, p. 1275.)

Concerning number of signatures for an Initiative Basic Science Law.

STATE OF CALIFORNIA
DEPARTMENT OF STATE
SACRAMENTO

March 18, 1937.

To the Editor:—Further with reference to our reply to your letter of the 9th, and replying to your letter of the 16th, concerning number of signatures necessary to qualify an Initiative measure to be submitted to the electors.

The figure of 186,378 is correct. That number will qualify any Initiative during the present year, or in the year 1938, to be submitted to the electors at the general election in November, 1938.

The total is determined by multiplying the total number of votes cast for all candidates for governor at the last preceding general election, at which a governor was elected, by 8 per cent, as provided in Section 1, Article IV, of the Constitution of California. At the November, 1934, general election the candidates for governor received 2,329,722 votes, 8 per cent of which is 186,378.

Very truly yours,

FRANK C. JORDAN,
Secretary of State.
By Charles J. Hagerty, Deputy.

Concerning syphilis legislation.*

CALIFORNIA MEDICAL ASSOCIATION

April 12, 1937.

To Presidents and Secretaries of County Societies:

Gentlemen:

By direction of the Council, your attention is called to the following statements. The members of your county society are requested to be accordingly governed when giving consideration to any local plans relating to a venereal disease program.

1. At the request of Surgeon-General Thomas Parran, United States Public Health Service, the Council on January 16, 1937, adopted the following motion:

WHEREAS, The federal, state and local public health agencies have authorized and are putting into operation carefully prepared plans for a campaign for the prevention and treatment of syphilis and gonorrhea; and

WHEREAS, The utilization of federal funds in this work necessitates centralization of state procedures in and through the California State Board of Health; now, therefore, be it

Resolved, By the Council of the California Medical Association, that it is in full sympathy with all rational and practical efforts to solve the problem of syphilis and gonorrhea; and be it further

Resolved, That this Council suggests that all groups and citizens who wish to cooperate in this work, do so in conjunction with the State Board of Health.

2. On February 7 the Council adopted the following resolution:

Resolved, That the Legislative Committee be instructed by the Council to support legislation for the control of venereal disease that is satisfactory in the judgment of the committee and that is also supported by the State Board of Health.

3. These resolutions were published in CALIFORNIA AND WESTERN MEDICINE, page 121 of the February issue, and page 190 of the March issue, and county secretaries were requested to impart this action to members.

4. Because of certain communications that are being addressed to county societies and members, the Council again requests that no official action be taken by your society or members until the nature of the indicated action is transmitted to your society after having been formulated by the Council or House of Delegates.

The Board of Health has given careful consideration to Assembly Bill 2790, and is of the opinion that it is necessary for the control of venereal diseases. The Board of Health and the Council of the California Medical Association do not endorse and do not deem that Assembly Bill 1089 is necessary.

The Board of Health has passed a resolution approving the policy that "As far as control measures are concerned, they must be carried out through official agencies—by the State and local health departments. We do not believe that we should be handicapped in framing rules and regulations by having the same written into the law. It will be necessary for the Board to promulgate certain regulations which can be changed from time to time as the occasion demands, and we would be very glad to discuss some of the features in Assembly Bill 1089 with regard to placing them in the regulations. On legal subjects we must be guided by the Advice of the Attorney-General."

The Council requests county societies and members to be governed by the foregoing statements.

F. C. WARNSHUIS, M. D.,
Secretary.

Concerning price advertising (Ward M. Whitten vs. California State Board of Optometry).

DEPARTMENT OF PROFESSIONAL AND VOCATIONAL
STANDARDS

BOARD OF MEDICAL EXAMINERS
STATE OF CALIFORNIA

MARCH 30, 1937.

To the Editor:—Supplementing our recent correspondence relative to price advertising, thought you would be interested in the enclosed copy of a California Supreme Court decision filed March 16, 1937, which upholds the right of the California State Board of Optometry to hear

* See also, in regard to Assembly Bill 2790, items on pages 294 and 348.

charges against one of their licentiates, Ward M. Whitten, who advertised "for sale complete glasses containing single vision lenses and including frames and examination for seven and 50/100 (\$7.50) dollars," but "refused to sell" the same for that price "to persons answering that advertisement."

Another most vital point in this decision is that boards such as the Optometry, Medical, and others, have the right to hold hearings and revoke licenses.

We believe this important decision is worthy of publication in CALIFORNIA AND WESTERN MEDICINE.

Very truly yours,

C. B. PINKHAM, M. D.,
Secretary-Treasurer.

IN THE SUPREME COURT OF THE STATE OF
CALIFORNIA

In Bank

FILED March 16, 1937

B. GRANT TAYLOR, Clerk

By J.

S. F. Deputy

WARD M. WHITTEN,
Plaintiff and Respondent,

vs.

CALIFORNIA STATE BOARD OF OPTOMETRY,
Defendant and Appellant.

This case was transferred to this court after decision by the District Court of Appeal, Second Appellate District, Division Two, in order that we might give further consideration to the propriety of the issuance of the writ of prohibition to restrain the respondent board from taking further action in proceedings to revoke the license of Ward M. Whitten for the making of untrue statements in his advertisement in violation of the Optometry Law (Stats. 1913, p. 1097). The action was commenced in the superior court and the peremptory writ of prohibition was ordered to issue. The Board prosecutes this appeal therefrom.

The office of the writ of prohibition is limited by the constitution to the restraint of a threatened exercise of judicial power in excess of jurisdiction and it does not lie to an officer or board exercising purely ministerial functions. (*Cameron vs. Kenfield*, 57 Cal. 550; *Baines vs. Zemansky*, 176 Cal. 369; *Santini vs. Justice's Court*, 218 Cal. 671). The Optometry Law provides for a State Board of Examiners in Optometry having statewide jurisdiction over the practice of optometry. Hence the case comes squarely within the rule, recently reiterated in the case of *Standard Oil Company of California vs. State Board of Equalization*, 92 Cal., December 7, that, in the absence of a constitutional grant of judicial power a state board cannot exercise judicial functions and the legislature is powerless to confer such power upon it. Hence the writ of prohibition is inappropriate. The fact that the Optometry Law fails to provide a method of review, perhaps by trial de novo in the superior court, is a matter for the consideration of the legislature.

The cases of *Millsap vs. Alderson*, 63 Cal. App. 518, and *Crisso vs. Board of Medical Examiners*, 95 Cal. App. 385, can no longer be considered as establishing that the legislature cannot confer upon the person deprived of a license or privilege the right to have his cause heard by way of a statutory review or trial de novo before the superior or municipal court. The distinction between the absence of authority in the legislature to enlarge or decrease the superior court's jurisdiction and its power to create or diminish rights, which, in effect, creates new or limits old causes of action, is well drawn in *Spreckels vs. Hawaiian Com. Company*, 177 Cal. 377, 381. See also *Wright vs. Superior Court*, 139 Cal. 469, and *Reclamation District vs. Superior Court*, 171 Cal. 672, 681.

However, it is suggested that the line of cases exemplified by *Suckow vs. Alderson*, 182 Cal. 247, and *State Board of Chiropractic Examiners vs. Superior Court*, 201 Cal. 108, should govern the instant case rather than *Standard Oil Company of California vs. State Board of Equalization*, supra. We are unable to find any substantial difference between the functions exercised. While it is true that in the authorities mentioned it is held that the writ of certiorari would lie to review the wrongful revocation of a license of a physician and surgeon on the theory that the medical board was exercising a quasi judicial func-

tion, we think that the sounder conclusion, in view of changing and increasing governmental activities, is that such boards are actually engaged in enforcing administrative determinations. Agencies engaged in making administrative determinations, unlike courts, have the power and the facilities to investigate and initiate action and, more or less informally, find the facts which under the law justify a course of action. They cannot and do not declare the law but perform the sole duty of ascertainment. (*Dominguez Land Corporation vs. Daugherty*, 196 Cal. 468, 483.) Under this theory the order of statewide agencies such as the Board of Optometry would not be subject to review in response to the writ of certiorari, but their discretion could be confined within legal limits either by the procedure heretofore suggested or by the use of the writ of mandamus.

Aside from the fact that the writ of prohibition will not lie, for the reasons already stated, we are of the opinion that the petitioner is not at this time entitled to any relief upon the showing made. He is accused of making untruthful statements, in this, that he advertised "for sale complete glasses containing single vision lenses and including frames and examination for seven and 50/100 (\$7.50) dollars," but "refused to sell" the same for that price "to persons answering that advertisement." No evidence was taken, this proceeding having been instituted before the time set for hearing. We can appreciate that under certain testimony it might be proven that the advertisement was not an untruthful statement, whereas, under other circumstances, it would be demonstrated to be untruthful and intentionally drawn to mislead. Certainly untruthful advertising should be held to constitute an untruthful statement. Under such circumstances the respondent board should be permitted to proceed.

Accordingly the judgment is reversed and the peremptory writ of prohibition is discharged.

THOMPSON, J.

We concur:

Decision unanimous.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

The Doctrine of Res Ipsa Loquitur (The Thing Speaks For Itself) as Applied to Malpractice Cases

Last month, in discussing the case of *Ales vs. Ryan*, the doctrine of *res ipsa loquitur* was mentioned, but discussion of the doctrine was deferred until this issue.

Ordinarily when a plaintiff commences action for damages arising out of an injury inflicted by the defendant to his person or property, it is necessary for the plaintiff to prove not only that the injury occurred and that he was damaged thereby, but that the injury occurred as the direct result of a negligent act or omission by the defendant. Once in a while, however, an injury is caused in such a manner that the plaintiff, in the nature of things, cannot prove the defendant negligent as conveniently or as easily as the defendant, if, in fact not negligent, can prove the absence of negligence. In such situations the law helps out the plaintiff by invoking a doctrine known as *res ipsa loquitur*, or "the thing speaks for itself." When this doctrine is applied, the jury is entitled to infer from the fact that the injury occurred that it was caused by the negligence of the defendant. Practically speaking, in such cases it is up to the defendant to convince the jury that he was not negligent, while in ordinary cases the burden is upon the plaintiff to convince the jury that the defendant was negligent.

Before a court will instruct a jury that "the thing speaks for itself" it is necessary for each of the following factors to appear:

1. The instrumentality causing the accident must be under the exclusive control of the defendant and the injury must be caused by some act or omission incident to that control;

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, containing copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

2. The accident must be of such nature that it ordinarily would not have occurred but for the defendant's negligence;

3. The accident must have occurred without any voluntary action or participation by the party injured; and

4. Information as to the cause of the accident must be more accessible to the defendant than to the plaintiff.

The case most often used to illustrate *res ipsa loquitur* is an English one where a barrel fell from the second story of a warehouse upon a person walking below. In that case the necessary factors were present, *i. e.*, (1) the defendant (owner of the warehouse) had exclusive control of the barrel which caused the accident; (2) ordinarily a barrel does not fall from a building unless it is negligently handled; (3) the pedestrian did not participate in any way in the barrel's fall; and (4) the precise cause of the barrel's fall could more readily be ascertained by the defendant than the plaintiff.

As expert evidence is *ordinarily* required to prove malpractice actions, it follows that *ordinarily* the *res ipsa loquitur* doctrine is inapplicable in such cases. In *Nicholas vs. Jacobson*, 113 Cal. App. 382, it is said:

Ordinarily, negligence on the part of a physician or surgeon must be proved by expert evidence, and when the matter in issue is one within the knowledge of experts only, and is not within the common knowledge of laymen, the expert evidence is conclusive. Hence, when the expert evidence fails to show negligence on the part of the physician or surgeon, and there is no evidence of an independent act or omission within the common knowledge of laymen, there is no ground upon which the jury may base an inference of negligence, and in such a case a nonsuit is proper.

Now and then a case arises involving an allegation of negligence in professional practice, which is said by the Court to be of such a nature that expert or opinion evidence is not necessary to prove negligence. In these cases, even though a professional act or omission is involved, the courts have applied the doctrine of *res ipsa loquitur*. An early example of this type of case is the one where an x-ray machine, attached to a wall in a dentist's office, fell, striking a patient who was sitting in the dentist's chair. The patient suffered a broken nose and other injuries to her face. In that case the Court held that it was only necessary for the patient to prove the machine fell and what injuries were sustained in order to entitle her to recover against the dentist. This case bears quite a resemblance to the early English barrel case mentioned above. However, some of the more recent decisions applying "the thing speaks for itself" doctrine against physicians and other professional persons seem to be far removed from the original judicial conception of the meaning of *res ipsa loquitur*.

In *Armstrong vs. Wallace*, 8 Cal. App. (2d) 429, the District Court of Appeal applied the *res ipsa loquitur* doctrine in a sponge case. The surrounding circumstances disclosed that no sponge count was made by anyone and that the operating surgeon did not bother to ascertain if one had been made.

In the case which we discussed last month, *Ales vs. Ryan*, 93 Cal. Dec. 28, the California Supreme Court held that *res ipsa loquitur* was properly applicable in a sponge case where the surrounding circumstances disclosed that a sponge count was made but, through the mistake of the nurses the operating surgeon was misinformed with respect to the count. It further appeared in *Ales vs. Ryan* that the surgeon testified that he made an independent search for sponges after the count had been reported to him. This case represents a clear extension of the *res ipsa loquitur* doctrine to an entirely new class of cases. When one considers that one of the conditions which must be present before *res ipsa loquitur* is applicable, is "exclusive control of the defendant" over the instrumentality causing the accident, and when one considers that the operating surgeon does not have exclusive control over the sponges used in an operation, it is clear that *res ipsa loquitur* now apparently means much more than it has in the past.

One cannot venture to prophesy future decisions of courts upon this or any other subject, but, unless great caution is used by the courts in applying the doctrine of *res ipsa loquitur* to cases involving professional acts, it seems clear that a grave injustice will be done the members of the medical profession. Professional acts rarely are of such a nature that juries can draw upon "common knowledge" to determine the presence or absence of negligence.

SPECIAL ARTICLES

PROPOSED PUBLIC HEALTH LAWS*

For the information of readers who may be interested, the following excerpts from the "Senate Weekly History" and the "Assembly Weekly History," of dates of April 16, 1937, and showing the status of certain measures in one or both of the legislative houses, are here given.

I. SENATE BILLS

5—Crittenden, January 18. To Committee on Constitutional Amendment.

Proposed amendment to Article XI of the Constitution, by adding Section 21 thereto, relative to hospitals maintained by cities, counties, or cities and counties.

January 18—Introduced. To printer.

January 19—From printer.

April 1—From committee, with recommendation: Do not pass. Reported correctly engrossed.

121—Williams, January 14. To Committee on Insurance.

An Act to amend Section 100 of, and to add Section 122 to, the Insurance Code, and to add Chapter 14 to Part 2 of Division 2 of said code, providing for the regulation of insurance against the need for medical and hospital services, defining such services, providing standard provisions for such insurance maintenance of reserves for the protection of insureds under such insurance providing for the licensing of persons entering into such contracts and rendering such services and providing penalties for the violation thereof.

January 14—Read first time. To printer.

January 15—From printer. To committee.

605—McGovern, January 21. To Committee on Public Health and Quarantine.

An Act to add Chapter 11B to Part 2 of Division 2 of the Insurance Code, authorizing the creation, organization and government, and providing for the regulation of public associations to be known as medical service associations, defining medical service contracts, providing standard provisions for such contracts, providing for the deposit of security by medical service associations, providing for certificates of authority for associations entering into medical service contracts, and rendering through members medical services and providing for the powers and liabilities of medical service associations.

January 21—Read first time. To printer.

March 1—From printer. To committee.

March 31—From committee, with recommendation: Be amended, and re-referred to committee.

April 1—Read second time. Amended. To print, and re-referred to committee.

II. ASSEMBLY BILLS

51—Heisinger, January 5. To Committee on County Government.

An Act to amend Section 4223 of the Political Code, relating to admission of county hospitals.

January 1—Read first time. To printer.

January 11—From printer. To committee.

684—Daley, January 18. To Committee on Public Health and Quarantine.

An Act to amend Section 5.190 of the School Code, relating to health and development certificates.

January 18—Read first time. To printer.

March 1—From printer. To committee.

1089—Beene, Cottrell, Boyle, Morgan, Turner, Welsh, Patterson, Cronin, Robertson, Dawson, Maloney, Clark, Peek, McMurray, and Hunt, January 20. To Committee on Medical and Dental Laws.

An Act to provide for the control, prevention, and cure of venereal diseases; providing for the establishment of a State Bureau of Venereal Diseases under the direction of the State Board of Health and defining its powers and duties; and providing for the granting of State financial aid for the control, prevention, and care of venereal diseases, and making an appropriation therefor.

January 20—Read first time. To printer.

January 21—From printer. To committee. Withdrawn from committee. Re-referred to Committee on Public Health and Quarantine.

March 15—From committee without recommendation, as amended.

March 16—Read second time. Amended. To printer.

March 17—From printer. To engrossment.

March 18—Reported correctly engrossed. Re-referred to Committee on Public Health and Quarantine.

April 6—From committee without recommendation, as amended. Read second time. Amended. To printer.

* See also editorial comments in this issue on page 294.

April 7—From printer. To reëngrossment. Reported correctly reëngrossed. Re-referred to Committee on Public Health and Quarantine.

April 16—From committee, with recommendation: Do pass as amended.

1132—Cronin, January 20. To Committee on Hospitals and Asylums.

An Act for the regulation and control of corporations organized for the purpose of operating nonprofit hospital service plans, and of hospitals rendering services under any such hospital service plans.

January 20—Read first time. To printer.

March 1—From printer. To committee.

March 22—From committee, with recommendation: Do pass as amended.

March 23—Read second time. Amended. To printer.

March 29—Read third time, passed, title approved. To Senate.

March 30—In Senate. Read first time, and referred to Committee on Insurance.

1196—Turner, January 20. To Committee on Government Efficiency and Economy.

An Act to amend Section 4223 of the Political Code, relating to county, city, or city and county hospitals.

January 20—Read first time. To printer.

March 1—From printer. To committee.

1262—Cronin, January 20. To Committee on Government Efficiency and Economy.

An Act to amend Section 372 of the Political Code, relating to the State Board of Public Health.

January 20—Read first time. To printer.

March 1—From printer. To committee.

March 10—From committee, with recommendation: Do pass.

March 11—Read second time. To engrossment.

March 12—Reported correctly engrossed. Read third time, passed, title approved. To Senate.

March 15—In Senate. Read first time, and referred to Committee on Public Health and Quarantine.

March 17—From committee, with recommendation: Do pass.

March 18—Read second time.

March 31—Read third time, passed, title approved. To Assembly.

March 31—In Assembly. To enrollment.

April 5—Reported correctly enrolled. To Governor at 3 p. m.

April 15—Approved by Governor. Chapter 49.

1283—Welsh, January 20. To Committee on Insurance.

An Act to amend Section 100 of, and to add Section 122 to, the Insurance Code, and to add Chapter 14 to Part 2 of Division 2 of said code, providing for the regulation of insurance against the need for medical and hospital services, defining such services, providing standard provisions for such insurance, maintenance of reserves for the protection of insureds under such insurance providing for the licensing of persons entering into such contracts and rendering such services and providing penalties for the violation thereof.

January 20—Read first time. To printer.

March 1—From printer. To committee.

March 26—From committee without recommendation, as amended.

March 29—Read second time. Amended. To printer.

March 30—From printer. To engrossment. Reported correctly engrossed. Re-referred to Committee on Insurance.

April 9—From committee without recommendation, as amended.

April 10—Read second time. Amended. To printer.

April 12—From printer. To reëngrossment. Reported correctly reëngrossed. Re-referred to Committee on Insurance.

1472—Pelletier, January 21. To Committee on Medical and Dental Laws.

An Act to regulate the practice of naturopathy; to create and appoint a self-sustaining Board of Naturopathic Examiners; to prescribe their tenure of office, powers, duties, compensation, etc.; to require and regulate the issuance of licenses to practice; to establish and collect fees for the examination of applicants and for the issuance and renewal of licenses; to define naturopathy; to define and qualify naturopathic colleges; to provide for the taking of examinations by qualified applicants; to segregate naturopaths from the State Medical Act; to provide for the assessment and collection of penalties for the violation of this Act; and to provide for the handling, custody, and disbursement of all funds collected under this Act.

January 21—Read first time. To printer.

March 1—From printer. To committee.

April 13—From committee without recommendation, as amended.

April 14—Read second time. Amended. To printer.

April 15—From printer. To engrossment.

April 16—Reported correctly engrossed.

1491—Cronin, McMurray, and Boyle, January 21. To Committee on Medical and Dental Laws.

An Act to add Chapter 11B to Part 2 of Division 2 of the Insurance Code, authorizing the creation, organization and government, and providing for the regulation of public associations to be known as medical service associations, defining medical service contracts, providing standard provisions for such contracts, providing for the deposit of security by medical service associations, providing for certificates of authority for associations entering into medical service contracts, and rendering through members medical services and providing for the powers and liabilities of medical service associations.

January 21—Read first time. To printer.

March 1—From printer. To committee.

March 30—From committee without recommendation, as amended.

March 31—Read second time. Amended. To printer.

April 1—From printer. To engrossment.

April 2—Reported correctly engrossed. Re-referred to Committee on Insurance.

April 16—From committee without recommendation, as amended.

1880—Clark, January 22. To Committee on Education.

An Act to amend Section 5,190 of the School Code, relating to health and development certificates.

January 22—Read first time. To printer.

March 1—From printer. To committee.

March 23—From committee, with recommendation: Do pass.

March 24—Read second time. To engrossment.

March 25—Reported correctly engrossed.

April 7—Read third time, passed, title approved. To Senate.

April 8—In Senate. Read first time, and referred to Committee on Public Health and Quarantine.

2790—Burns, Hugh M., March 8. To Committee on Public Health and Quarantine.*

An Act relating to the care and control of venereal diseases, granting other and further powers in relation thereto to the State Board of Public Health and its subordinate agencies, authorizing the acceptance of Federal Social Security funds and making an appropriation therefor.

March 8—Read first time. To printer.

March 9—From printer. To Committee.

April 16—From committee, with recommendation: Do pass as amended.

HOSPITAL CONVENTION AT LOS ANGELES

Association of Western Hospitals, Association of California Hospitals, and Western Catholic Hospital Association

The hospitals of eleven western states have just finished a most successful convention in Los Angeles (April 12-15). Over two thousand delegates registered and attended the sessions at the Biltmore Hotel which featured a number of new innovations and departures from past policies. Instead of the usual convention with a competing three-ring circus and a consequently over-crowded program, the program committee chose to very thoroughly develop and discuss six major topics.

The first session started Monday afternoon considering the subject, "The Manifold Obligations of Hospitals to the Public." Dr. Benjamin W. Black, Medical Director of the Alameda County Institutions, gave the opening address and in his characteristic manner ably handled the subject, starting the program off with the proper enthusiasm and momentum. He emphasized that although hospitals do have manifold obligations, the primary obligation of hospitals is patient welfare and that all other obligations are subsidiary thereto. He stressed among others, the obligation of leadership in public health, teaching, and in public education. His address was ably discussed by George B. Mangold, Ph.D., University of Southern California, Dr. John Wilson, Los Angeles County General Hospital, Mr. Frank Van Dyk, Executive Director Associated Hospital Service, New York City, Dr. Louis B. Boonshaft, Director, Los Angeles County Relief Association, Mr. W. C. Cran-

* See also items on pages 294 and 345.

dall, Director, Scripps Memorial Hospital, La Jolla, California.

On Tuesday morning, the convention was addressed by Mr. Howard Burrell, Attorney, Los Angeles, on "Legislation and Hospitals." Handling this in a proper neutral attitude, Mr. Burrell crystallized the attention on the various types of legislation confronting hospitals at the present time. He went further than actual legal code and discussed court decisions which have become equally as important as legislation. His address was discussed by Mr. Thomas F. Clark, Executive Secretary, Association Western Hospitals, Mr. Clifford Mack, Superintendent, Livermore Sanitarium, Mr. William P. Butler, Manager, San Jose Hospital, Dr. H. H. Johnson, Superintendent, St. Luke's Hospital, San Francisco, C. Rufus Rorem, Ph.D., Representative, American Hospital Association. This session proved to be not only a study of the history of legislation but a guide for future legislative policies for hospitals.

Tuesday afternoon, the convention was addressed by Mr. Frank Van Dyk, Executive Director, Associated Hospital Service of New York, C. Rufus Rorem, Ph.D., Director, Committee on Hospital Service of the American Hospital Association, the subject being "Group Hospitalization." Both Dr. Rorem and Mr. Van Dyk proved to be competent authorities on this problem—Dr. Rorem from his long study of this problem under the American Hospital Association and Mr. Van Dyk in light of his experience as Director of the largest Hospital Service Plan in the United States, now numbering nearly three hundred and fifty thousand members. Both of these speakers emphasized the public service of this plan of budgeting sickness costs—particularly pointing out that Group Hospitalization is primarily a solution of the patient's economic problem and only incidentally beneficial to the hospitals. These addresses were ably discussed by Mr. R. D. Brisbane, Superintendent, Sutter Hospital, Sacramento, Dr. B. C. MacLean, President, American College of Hospital Administrators, Mr. Philo Nelson, Executive Director, Insurance Association of Approved Hospitals, Oakland, Mr. A. G. Saxe, Superintendent, Mt. Zion Hospital, San Francisco, Mr. Roland Maxwell, Attorney, President Methodist Hospital Association, Los Angeles, Mr. R. E. Heerman, Superintendent, California Hospital, lead this discussion hour and emphasized that in Southern California the hospitals themselves were anxious and ready to proceed, some twenty-seven hospitals having already signed qualifying papers and were held up by the necessity of legislation now under consideration at Sacramento enabling their Association to proceed.

On Wednesday morning, Dr. Claude W. Munger, President, American Hospital Association, addressed the convention on the subject "The Interest of the Patient Is Paramount." He stressed the responsibility of the hospitals for providing scientific progress to assure safety and proper sanitation facilities—but beyond these, which he considered minimums in hospital care, he stressed the necessity for considering the new psychologic aspects of the care of patients. He emphasized the necessity of further study in psychiatrics—the training in this subject of nurses, doctors, and the public. He predicted that far greater use of this modality can be expected and that the benefits will be surprisingly beneficial. He placed particular attention on the science of dietetics and predicted further development in this line. Under the leadership of Dr. B. C. MacLean, Superintendent of Memorial Hospital, Rochester, New York, Dr. Munger's address was ably discussed by Rev. Joseph S. O'Connell, Ph.D., Assistant Director of Catholic Hospitals and Division of Health in the Archdiocese of New York; Dr. Alan Benner, Superintendent, San Mateo Community Hospital, San Mateo; Miss Alice Henninger, Superintendent, Huntington Memorial Hospital, Pasadena; Dr. Malcolm T. MacEachern, American College of Surgeons; Miss Reeve Hinyon, Dietitian, California Hospital, Los Angeles.

Wednesday afternoon the session was opened by Dr. B. C. MacLean, who addressed the convention on the subject "The Growth, Causes and Cures of Malpractice Suits." Doctor MacLean very ably presented the problem and through the use of lantern slides gave interesting statistics supporting his discussion. His address was a very capable presentation of a serious hospital problem. Following Doctor MacLean's address, the convention staged one of its

interesting innovations, namely, a mock trial of a malpractice suit. This session proved to be highly interesting and entertaining as well as instructive on this grievous problem. The case of *McGillacudy vs. Lying Down Memorial Hospital* will long be remembered by the many delegates who packed the assembly room and willingly remained forty-five minutes beyond the prescribed hour of adjournment. The trial was conducted realistically under the leadership of Roland Maxwell as Judge, William Rains as Prosecuting Attorney, and Raymond G. Stanbury as Defense Attorney. Many common errors and mistakes were dramatized and searchingly driven home by examination and cross-examination. The law on the subject was very interestingly presented by Judge Maxwell in his charge to the jury. The verdict was in favor of the plaintiff.

At 8:30 on Wednesday evening, the delegates assembled at the Biltmore Rendezvous for their annual banquet. A very high spiritual note was introduced into the convention by Professor Ordway Tead, Columbia University, who addressed the banquet guests on the subject "Can We Have Faith in the Future?"

On Thursday morning, delegates of the convention listened to an address by Dr. Ordway Tead, Lecturer on Personnel Administration, Columbia University, on the subject "Employee Welfare in the Broader Sense." Doctor Tead emphasized the necessity of promulgating in the employee group itself the high motives of hospital service. He drove home the necessity of studying administration itself as scientifically as doctors do the practice of medicine. He candidly discussed the problem of labor unrest which for the first time has reached out and affected hospitals. He urged that administrators approach this problem with an open mind and do the job constructively rather than obstructively. In the discussion which followed later, under the leadership of Mr. William P. Butler, a very spirited attack was made upon this problem. Mr. H. S. Barnes, Superintendent, Latter Day Saints Hospital, Salt Lake City, Utah; Dr. W. S. Mortensen, Medical Director, Santa Monica Hospital, Santa Monica, Calif.; Dr. Basil C. MacLean, Strong Memorial Hospital, New York; Mr. R. G. Walker, Assistant Superintendent, California Hospital, Los Angeles, and Dr. Malcolm T. MacEachern, gave varying and personal viewpoints on this challenging subject—differences of opinion were expressed and the delegates were highly interested.

In addition to these general assemblies, sectional programs of exceptional merit were provided by Auxiliary and Volunteer services—cancer clinics, dietitians, hospital pharmacists, trustees, medical social workers, public hospital administrators, and record librarians. Capacity audiences attended all of these sessions and were highly pleased with the programs presented. The consensus of opinion of the delegates, assembling in greater number than ever before, is that this was the most interesting and successful convention ever held on the Pacific Coast.

THE PACIFIC COAST ABORTION RING*†

The Pacific Coast abortion ring has been smashed. The curtain has been rung down on a "racket" as inconceivable in its intimate details as any tale not excepting those found in the Arabian Nights.

This illegal operation project was conceived by Reginald L. Rankin, whose egotism was so self-inspiring that he believed he was "above the law." Said he, "We fear no trouble, for we have the best legal advice." A native of Oregon, former woodsman, timber cruiser, etc., he came to California some twenty-five years ago. The knowledge gained as a "timber cruiser" was put to good use when a

* From the annual report for 1936, Board of Medical Examiners of the State of California, Charles B. Pinkham, M. D., Secretary-Treasurer.

† The Board of Medical Examiners of the State of California has as members: William R. Molony, Sr., President, Los Angeles; Clark L. Abbott, Vice-President, Oakland; Charles B. Pinkham, Secretary-Treasurer, San Francisco; Harry V. Brown, Glendale; Fred R. DeLappe, Modesto; Frederick W. Didier, Wheatland; Percival Dolman, San Francisco; William H. Geistweit, Jr., San Diego; Charles E. Schoff, Sacramento; George Thomason, Los Angeles, Legal Counsel—Attorney General U. S. Webb, San Francisco. Investigation Department—Thomas P. Hunter, Special Agent, San Francisco; Albert Carter, Special Agent, Los Angeles; John Ronan, Assistant Special Agent, Los Angeles.

short time after his arrival in California he handled some disputed tax matters involving some land in San Diego County. Early in 1913 he became well known in Sacramento, where he married. His success in the San Diego affair led him to overestimate his ability.

When late in 1933 he started his meteoric career as promoter of the Pacific Coast abortion ring (which ended in October, 1936, with a state prison sentence) his business card announced him to be a "Tax Factor, Evaluation Engineer and Expert on Income Tax Matters," with offices in the Walter P. Storey Building, 610 South Broadway, Los Angeles. He boasted he was too smart to be caught by law enforcement officers. His false claims of political influence and that the Board of Medical Examiners approved his scheme led some thirty or more individuals to join with him in operating a gigantic illegal operation ring which involved the states of California, Oregon and Washington.

Comment on the Pacific Coast racket appeared in the *Allied Council News*, Denver, Colorado, March 29, 1935, under the heading "The Alleged Abortion Racket—The California Ring—An alleged abortion ring which threatens to become nationwide in scope, is now operating on a chain store basis in the major cities in California. . . . An investigation, the results of which have just been made public, reveals that this syndicate, it is said, employs attractive women to solicit trade, especially among high school girls, soliciting them for illegal operations. The syndicate pays \$10 commission for every case referred. The standard price for abortions is \$50. The investigation is being conducted by Charles B. Pinkham, Secretary of the California State Board of Medical Examiners. . . ."

In this organization were:

1. A crew of salaried abortionists consisting of both physicians and surgeons licensed in California and unlicensed operators;
2. A staff of salaried solicitors for state-wide distribution of the business cards of the ring;
3. Offices in San Francisco, Oakland, San Jose, Los Angeles, Hollywood, Long Beach, San Diego, Portland, Oregon, and Seattle, Washington;
4. Private hospitals or "nursing homes" for cases that developed complications;
5. A fleet of airplanes with landing fields both in Oregon and on an isolated ranch hidden in the mountain regions of a Northern California county. The latter was the only level piece of property for miles around. It was purchased ostensibly as a "dude ranch." However, its asserted function was to provide either a "hideout" for any of the operators of the "racket" who might become involved in a police investigation or to provide a "haven" for any operated case that might go "bad."

The keystone of the racket was the Medical Acceptance Corporation. Its main office was in the Signal Oil Building (Room 205), Los Angeles, in close proximity to the office of Dr. George E. Watts, convicted in connection with the Pacific Coast abortion ring. An office of this finance organization was located in every major Pacific Coast city, always in the same building where the abortion syndicate maintained an illegal operation office.

The Seattle office of the Medical Acceptance Corporation, 1904 Third Avenue, Suite 314 (Securities Building), opened on or about October 10, 1935, and W. W. Macfarlane was appointed resident manager. However, he said he resigned about December 19, 1935, when he learned of the type of organization and the work they were doing. The Seattle office, about February, 1936, was moved to the Shafer Building, Seattle, in close proximity to the office of Dr. W. Norman Powers, also convicted in connection with the Pacific Coast abortion racket, whose California medical license was revoked March 11, 1936.

A business card which came to the Board of Medical Examiners during our investigation read, "Medical Acceptance Corporation, 1916 Broadway, Oakland, California, J. M. Lotta, Mgr., Phone HOliday 5771." Another business card received about the same time read, "The American National Detective System, J. M. Lotta, Mgr., Tapscott Building, 1916 Broadway, Oakland. . . ." At this same address Dr. James Beggs (also convicted), assertedly operated one of the offices of the Pacific Coast abortion ring.

The San Francisco office of the Medical Acceptance Corporation was in Rooms 519-520 Elkan Gunst Building, Geary and Powell Streets, San Francisco. In the same building, Room 617, was the office of Dr. James Beggs, and (after Beggs's removal to Oakland), later occupied by Dr. Jesse C. Ross, both convicted in connection with the Pacific Coast abortion ring.

This finance organization furnished unwed mothers with funds to pay for operations performed by doctors on the pay roll of the "syndicate." This racket reversed the old adage, "Let not your right hand know what your left hand doeth." The promoters of the Pacific Coast abortion racket, through its Medical Acceptance Corporation, lent money at usurious rates to its victim in one office, then sent her to another office in the same building where said loan was taken as payment for an asserted illegal operation. R. L. Rankin, president of the Medical Acceptance Corporation, was quoted as saying, "We turn our money over every ninety days."

Whenever a woman sought treatment at any of the offices of the Rankin-Watts abortion syndicate, she was required to write her name on the first line and sign the affidavit at the bottom of a "Case Record," which read as follows:

I, being first duly sworn, depose and say that I voluntarily applied to Dr. for treatment on the above date; that my condition demanded immediate attention; that there was nothing of a criminal [sic] or unprofessional nature in the treatment given me; and that I have read the above, and am fully aware of its contents and that the same is true.

(Signed)

Subscribed and sworn to before me this day of, 19

Notary Public for California.

My commission expires, 19

Reports relate that Dr. George E. Watts acted as notary in signing and sealing these affidavits. It is obvious that these were to be used as an alibi should a case go "bad" and any member of the Rankin-Watts abortion ring be charged with performing an illegal operation.

Police reported when, on June 6, 1936, they raided the offices of the Medical Acceptance Corporation, they found about 70 per cent of the "paper" for loans made were for patients of Dr. George E. Watts, seeking relief from pregnancy.

In many instances such an operation was unnecessary because no pregnancy existed. However, that made no difference to the racketeers. Advertisements were inserted in metropolitan daily papers offering pregnancy tests by examination of urine. The abortion syndicate offices claimed to diagnose accurately pregnancy by such an examination. Their procedure assertedly was pure "hokum," because, according to one familiar with the racket, regardless of whether the specimen submitted for examination was from a female or male, a diagnosis of pregnancy was always made.

How intriguing has been the story of this abortion syndicate, as it was gradually unfolded during three years' investigation by the California Board of Medical Examiners, constantly endeavoring through its secretary to discover some clue on which concerted action could be taken to "round up" the entire outfit at one fell stroke.

Betrayal of the trust placed by the Board of Medical Examiners in certain members of its investigation department was indicated early in our study of the various angles of this case. Confidential information both as to conversation and correspondence mysteriously found its way to the leaders of this racket. These "leaks" regarding the progress of our investigation indicated a traitor in our employ. The secretary of the board had his suspicions as to the guilty party. A special meeting of the board was called and employment of a Special Investigator to investigate the board's *Investigation Department*, was authorized. His service began in 1935. Only three people knew his identity, i. e., President Dr. William R. Molony, Secretary Pinkham and a man of unimpeachable integrity who recommended this undercover man. Reports soon warranted the board's ousting our guilty investigator. He was later indicted by the grand jury in San Francisco, as well as Los Angeles, convicted on five counts of the indictment and sentenced to ten to twenty-five years in the penitentiary.

Meanwhile Rankin believed because he had influenced an investigator of the Board of Medical Examiners to turn traitor to his employers and to become his traveling companion, as well as the "front" man in his nefarious deals, that his racket was firmly entrenched. Our investigation disclosed that R. L. Rankin and William Byrne, Investigator for the California Board of Medical Examiners, on October 8, 1935, arrived in Seattle, Washington, via plane. Both registered in the Olympic Hotel at the same hour, 4:13 p. m., occupied adjoining rooms (935 and 937) and checked out at the same time (October 11, 1935, at 11 a.m.). A conversation was held in the Seattle office of the Pacific Coast abortion chain, during which (according to report) it was agreed one of the doctors should drive Byrne to Olympia to try and interest Mr. Harry Huse, Director of Licenses, State of Washington, in the racket. That Byrne did call on the date mentioned was verified by Mr. Huse in a letter to Secretary Pinkham of the California Board.

On Byrne's return to Seattle he reported to Rankin that Mr. Huse was not interested. This assertedly depressed Rankin, who expressed the hope that he might interest Mr. Huse in his subsidiary organization, *i. e.*, the Medical Acceptance Corporation.

While at the Olympic Hotel, Seattle, Rankin telephoned to Los Angeles, California, to one of his associates, Joseph Shinn, secretary-treasurer of the Medical Acceptance Corporation, an asserted director of a Santa Monica bank, in reference to a case said to have been operated on by Dr. Harry Houston in the Long Beach office of the syndicate, which had "gone bad." This patient was then under treatment in the Los Angeles County Hospital. Rankin assertedly requested Shinn to arrange a "pay off" to avoid trouble. Byrne is quoted as having told Rankin he should not have given this instruction to Shinn, as he (Byrne) had the case "fixed." The victim in this case was mentioned as a witness in the Los Angeles trial of the abortion syndicate principal and was quoted as having verified this "pay off."

Rankin called, in November, 1934, on Secretary Pinkham in the San Francisco office of the Board of Medical Examiners and among other statements said he handled all the income tax matters for the abortionists in various Pacific Coast cities, among them being Dr. George E. Watts of Portland, Oregon, who, desirous of opening a practice in California, had requested Rankin to make such a purchase. When told he and his associates would be prosecuted, he boasted he had no fear because of his asserted "influence."

Investigation reports indicated that the procedure used by the leaders of the abortion racket in negotiating the purchase of a "business" was as follows: First, Promoter Rankin would call and make an offer to purchase the business. He would be followed by an investigator for the Board of Medical Examiners, since dismissed, convicted and sentenced to San Quentin Prison. The latter, without intimating that he had knowledge of the visit of the "promoter," would announce he was aware of the character of the business engaged in and threaten arrest if the individual continued same. A few days later the "promoter" would make his second call, renewing his offer to purchase. He would boast of his political influence and as a demonstration thereof would promise to have an investigator of the Board of Medical Examiners call the next day. A sale invariably followed. One Long Beach prospect refused to sell, arguing, "Why should I sell to these racketeers? I have as much right to perform abortions as they." As a result of this refusal a fake arrest of the office nurse was staged. She assertedly was virtually kidnapped as she left her employer's home, thrown into an automobile and whisked away to some unknown "hide out."

Rankin's first purchase of a practice in California was that of an old time practitioner in the Arcade Building, Los Angeles. About April, 1934, Rankin brought Dr. George E. Watts from Portland, Oregon to take over this practice. After a few operations had been performed in the Arcade Building, this practice was moved to Room 210, Signal Oil Building, 811 West Seventh Street, Los Angeles. Dr. Watts, although a non-resident of this state, had been licensed in California in 1899 by the then existing easy process prescribed by law, *i. e.*, by filing his medical college diploma and a fee of \$5.

Soon after Dr. Watts arrived in Los Angeles the California Board of Medical Examiners received a note postmarked Portland, Oregon, relating that Dr. Watts, for-

merly of Portland, had located in the Signal Oil Building, Los Angeles, and proposed to "open up a chain of abortion offices in Washington, California and Oregon." We thereupon started an investigation of his past practice. Reports indicated he had practiced for many years in Portland, Oregon, sharing with a Dr. J. W. Morrow an office at 212 Oregonian Building, Portland, Oregon. His practice assertedly had consisted of abortions and, although he had been called before the Oregon Board of Medical Examiners on several occasions, he had escaped punishment because of the difficulty to get the evidence required under the Oregon law.

On or about February 2, 1935, R. L. Rankin registered at the St. Francis Hotel, San Francisco. In response to his telephoned request, two individuals known to the Board of Medical Examiners came to his room. Negotiations were opened for the purchase of the property at 2240 Van Ness Avenue, San Francisco, then said to be owned by a resident of Vallejo. These premises had been occupied previously by Harley H. Heddens, erstwhile civil engineer abortionist, convicted by the Board of Medical Examiners in Bakersfield in 1926. On October 18, 1936, following his plea of guilty of manslaughter, Heddens was sentenced to San Quentin Prison by Los Angeles Superior Judge Joseph Vickers for a term of three to fifteen years. In passing sentence Judge Vickers stigmatized the defendants (Heddens, his wife and an assistant) as "the worst illegal operation ring ever to come before the court." "This is a sordid case," he said. "There is no way of telling how many women suffered at the Heddens' clinic. Heddens, an electrical engineer, knowing nothing whatever about the science of medicine, deliberately took the lives of these women into his hands. It is clear by the excellent work of the police and the district attorney in this case that you (the defendants) have performed one hundred or more illegal operations. Not only did you perform these illegal acts, but you did it in the most crude manner possible and without an iota of medical skill."

As a sequel to Rankin's conversation with these "two known individuals" at the St. Francis Hotel, San Francisco, a check for \$250 was passed by Rankin as down payment on the property at 2240 Van Ness Avenue, San Francisco, and the title thereafter (as well as the Heddens' telephone number), was transferred to the Rankins.

Paul de Gaston, erstwhile photographer, who about 1934 held the photograph concession in one of San Francisco's well-known department stores, succeeded Heddens at 2240 Van Ness Avenue. A jury in a Los Angeles superior court assertedly twice disagreed in 1935 as to his guilt following trial on an illegal operation charge. The discredited investigator for the Board of Medical Examiners was said to have had a hand in tampering with witnesses for the prosecution in this case.* De Gaston was one of those indicted and testified for the prosecution in the Los Angeles trials of the Pacific Coast abortion ring.

In the meantime the Rankin-Watts syndicate opened an office in the Kress Building, Long Beach, and Dr. James Beggs was placed in charge. This office was later moved to the Ocean Center Building with Dr. Harry L. Houston in charge because Dr. James Beggs had been sent to take charge of the San Francisco office in the Elkan Gunst Building.

The practice of another Los Angeles physician was purchased by the Rankin-Watts combination in May, 1935. The statements of this second physician indicate "strong arm" methods were employed by the party or parties interested in making the purchase. Among these was an asserted threat to "bump off" this doctor if he refused to sell. A similar threat assertedly was made to another Los Angeles doctor whose "practice" was desired by the syndicate. A short time later the doctor referred to was killed in an automobile accident under conditions that aroused suspicions.

Investigators reported that in the bill of sale by which a "business" was purchased in Oakland was a clause that in case of the death of the "seller," the property would immediately be possessed by the purchaser. Shortly thereafter the Oakland doctor, whose "business" had been purchased, died. The authorities threatened to exhume the body, but did not do so.

* Los Angeles *Evening News*, October 9, 1936.

About this time Rankin purchased the offices operated by Dr. Jesse C. Ross at 6331 Hollywood Boulevard. Then, according to investigation reports, followed in rapid succession the purchase or opening of offices in several other Pacific Coast cities, *i. e.*, Tapscott Building and 3849 Grove Street, Oakland; Dr. Frank Hart, Josiah Green Building, Seattle (June, 1935); Dr. William Norman Powers, Bratlin Building, Seattle (July, 1935); E. B. Fromm (sanipractor), 515 Arcade Building, Seattle; Room 407 Commonwealth Building, San Diego; Elkan Gunst Building, San Francisco, and 899 Jackson Street, San Jose.

Early in our investigation we learned that a licensed chiropractor named L. J. Giubbini had been practicing in San Jose since his departure from San Francisco, where he had been watched by our investigation department because of reports received in February, 1931, of the irregularities of the practice he conducted in his office in the Liberty Bank Building, San Francisco. In June, 1931, our former investigator, J. W. Davidson (deceased), reported that with a member of the San Jose Police Department he had called on Giubbini, Rooms 502-3 First National Bank Building, San Jose, and warned him that the character of his business was known and if continued he would be arrested. Although Giubbini moved from the First National Bank Building to 265 South Eleventh Street, and later to 899 Jackson Street, San Jose, the warning apparently was not heeded, judging from the following incident uncovered after we had started our investigation of the Pacific Coast abortion ring. This information was sent to Secretary Pinkham by the distracted father of the deceased. Those who have daughters may well shudder at the gruesome tragedy and pray it may never strike home.

Pathos involved every line of what proved to be the death note of a fear-stricken daughter written November 24, 1932, to her devoted father. The heartbreaking sermon in that letter strikes to the very heart of fond parents and law abiding citizens. Said she:

Dear Papa—I want you to know this in case anything happens to me—Tomorrow I am going to San Jose to the Pacific Bacteriological Laboratory—to a doctor for an illegal peration. . . . If I don't come back please remember I am telling the truth. I don't know the doctor's name, but Marvin Raithel* who works for the Lyne Drug Company there does, as it is through his appointment. . . . You will hear from me in a few days if I am all right. . . .
Much love (Signed) V.

On arriving at the house of death she penned a short note, reading:

Papa—this is the place—change address—899 East Jackson St. Two-story white house—San Jose.

Death closed her career four days later at 899 Jackson Street, San Jose. The death certificate gave the cause of death, "Epileptic (note spelling) Seizures," and was signed Joy V. Simmons, 899 East Jackson Street (San Jose). The "Proof of Death" certificate to an organization in which this poor girl was insured, showed as attending physician a signature purporting to be that of Joy V. Simmons. Underneath was written "Per Dr. L. J. Giubbini, Assistant," 899 Jackson Street, San Jose, Calif. This "Proof of Death" certificate shows it was sworn to before Edward A. Uhl, notary public, San Jose, by Dr. L. J. Giubbini, January 30, 1933.

On November 28, 1932, a grief stricken father from a northern California town wired:
Chief of Police,
San Jose, California.

My daughter, Mrs. A. Dryden, died there today. I have sufficient reason to request that a very strict examination be made into this case to determine the cause of death. . . . Answer.

(Signed).....

That the father of the deceased discussed the matter with the Santa Clara County district attorney is shown by the following letter dated San Jose, January 6, 1933, addressed to him:

This office has investigated quite thoroughly the facts of the case which you discussed with Mr. Fred L. Thomas, District Attorney of this county, and also with Mr. Chesley M. Douglas, Assistant District Attorney, on December 13, 1932. By our investigation we have not been able to obtain sufficient information to warrant action

being taken against either one of the parties against whom you made the complaint. We will, however, continue our investigation and if at any future time we are able to obtain what appears to be sufficient information to warrant complaints being issued, we will advise you further in the matter. If we can be of any further assistance to you do not hesitate to call on us. . . .

(Signed).....

What of the subsequent history of the premises, 899 Jackson Street, San Jose, where the death occurred? In a letter addressed to the Secretary of the Board of Medical Examiners, dated San Jose, October 1, 1936, the following information is given:

San Jose, Calif.,
October 1, 1936.

Mr. C. B. Pinkham,
Sacramento, Calif.

Dear Sir: Your letter a few days ago, in reply will say L. J. Giubbini purchased the property at 899 E. Jackson on August 28, 1932, of Lucy H. Neher later my wife, Mrs. Charles E. Ritter, who died June 8, 1934. Giubbini assumed one mortgage of \$3,000 and one \$1,400, then gave a third mortgage of \$3,700 to Mrs. Neher, then L. J. Giubbini was to pay \$55.00 per mo. on the \$3,700.00 loan, which he did until paid down to \$2,640.00. Then in October, 1935, leased the building to a Mr. Ranken, I believe, but in September, 1932, L. J. Giubbini deeded the property to his father, L. D. Giubbini, at 1734 Lyon Street, San Francisco, Calif., but lived at said place until October, 1934. In November, 1935, he discontinued paying the \$55.00, also was back on the \$3,000 and \$1,400 mortgage, so I was compelled to start action of foreclosure, which I did January, 1935. Thirty days later his father offered to except \$50.00 for deed to me as I held the Neher mortgage which my wife had willed to me, as she had passed on. Then L. J. Giubbini moved to a place owned by his father L. D. Giubbini at Livermore, Calif., known as the Fountain Hospital, No. 24 Tel. Phone. This is all I can give you in regard to L. J. G.

Yours truly,

(Signed) CHAS. E. RITTER,
899 E. Jackson,
San Jose.

The above letter indicates that R. L. Rankin, asserted head of the Pacific Coast abortion ring, took over the premises in October, 1935. A nurse named Violette Pelligrini, said to be a former employee of Giubbini, thereupon continued as nurse-employee of Rankin, who according to court records, placed Dr. Jesse C. Ross in charge. The latter, following conviction by a Los Angeles jury in connection with the Pacific Coast abortion racket, was sentenced to ten to twenty-five years in the state penitentiary at San Quentin. Another nurse named Tieman, employed on the premises, testifying* during the recent Pacific Coast abortion ring trials in Los Angeles, related a most gruesome procedure which she assertedly saw. Her story involved the asserted "cutting up" of a foetus born alive on the premises, 899 Jackson Street, San Jose. Nurse Pelligrini was sentenced to one year in the Los Angeles county jail following her conviction in connection with the Pacific Coast abortion racket.

But I am ahead of my story, so let us pause and learn more about this Joy V. Simmons, whose name was signed to the previously mentioned death certificate of V. D.

The records of the Board of Medical Examiners show he secured a diploma from the Western College of Chiropractic, dated San Francisco, June 20, 1923; that shortly thereafter he was denied admission to the written examination for drugless practitioners under the medical act. He appealed and the board was compelled by action of the San Francisco superior court to grant Simmons a drugless practitioner certificate. According to police records, Simmons thereafter gained a criminal record which culminated in his conviction in Los Angeles of abortion, assertedly performed at 8712 Darrington Avenue, Beverly Hills, on November 30, 1933, and his being sent to San Quentin for a "term prescribed by law." His drugless practitioner license was revoked March 1, 1934.

Our investigation indicated that in November, 1933, one calling himself J. V. Roberts was at 899 Jackson Street, San Jose (keep the address in mind). The San Jose Merchants Association at that time was interested in learning whether J. V. Simmons, 260 North Third Street, San Jose, was the same as J. V. Roberts, 899 Jackson Street,

* Again mentioned on page 15.

* Los Angeles Herald-Express, October 23, 1936.

San Jose. The latter premises had been reported by our investigation department as the headquarters of L. J. Giubbini, licensed chiropractor. That J. V. Roberts and Joy Simmons were one and the same individual was indicated by the death certificate already mentioned.

During the year 1935 the Pacific Coast abortion racket had reached its peak with offices doing a land office business in Seattle, Washington; Portland, Oregon; San Francisco, Oakland, San Jose, Los Angeles, Hollywood, Long Beach and San Diego. Rankin in an asserted dictaphone conversation was "caught" as boasting that one office alone last year (1934) "had handled 1400 cases and the entire organization handled 4400 cases."

Attorney Buron Fitts of Los Angeles, Chief Deputy Chamberlain in the office of District Attorney Earl Warren of Alameda County, Captain of Detectives Charles Dullea and the homicide squad of the San Francisco Police Department had been advised of the magnitude of the racket. The secretary of the Board of Medical Examiners by correspondence and in personal interviews had given complete and detailed information to these enforcement officers. All were waiting for that "break" which eventually would make possible the final clean up of the entire racket. Captain Dullea had detailed two of his best inspectors to "smoke out" the racket, which with headquarters in Los Angeles was rapidly spreading to other states. The "break" came unexpectedly one afternoon when San Francisco Police Inspectors George Engler and Harry Husted were browsing about the Elkan Gunst Building, San Francisco. They casually called at the office of Dr. Jesse C. Ross. While there a young man came in and asked for "Mr. Rankin" and left when told by the nurse that Rankin had not been in. The officers then stepped into the office of the Medical Acceptance Corporation and there saw the same young man. Regarding him with suspicion and convinced he had an intimate acquaintanceship with the personnel of the offices, they suggested he accompany them to headquarters. In his automobile were found hundreds of the "business cards" of the various offices of the abortion syndicate, each bearing the name of the doctor in charge, all bound in packages of about 50 each, perforated so as to be easily torn from the binding. These he said he passed out in drug stores and other places, with directions they be given to any woman seeking relief from pregnancy. On arrival at headquarters this young man gave his name as Marvin Raithel,* drug clerk by vocation, and acknowledged he was a salaried solicitor for the abortion racket. Captain Dullea, with Inspectors Engler and Husted, and assisted by the police department stenographer, took a two-hour statement, in which were revealed the intimate details of the entire organization. Responding to a call from Captain Dullea, the secretary and an investigator for the Board of Medical Examiners joined in quizzing Raithel. Here at last was conclusive evidence by which the long investigated Pacific Coast abortion racket could be smashed. San Francisco District Attorney Brady detailed his assistant, John McMahon, to the case, to whom great credit is due for his persistent and self-sacrificing work. Alameda County Assistant District Attorney Coakley was summoned and the raids commenced. First to the offices in the Elkan Gunst Building, where most important information, card records, etc., were seized and taken to headquarters. The following day Assistant District Attorney McMahon, with Inspectors Engler and Husted, and accompanied by Alameda Assistant District Attorney Coakley, flew to Los Angeles, where with trusted investigators from the office of Los Angeles District Attorney Buron Fitts, offices of the syndicate in Hollywood, Los Angeles and Long Beach were raided. Truckloads of material, records, etc., were confiscated and shipped to San Francisco to remain in custody of the authorities.

A short time thereafter Deputy District Attorney McMahon and Inspector Engler raided the San Diego office of the syndicate. They found Laura Miner in charge of the office with Nedra Arden. Valuable statements were taken and Laura Miner afterward testified for the prosecution in the Los Angeles trials.

Assistant District Attorney McMahon, Captain Charles Dullea, with Inspectors Engler and Husted, worked night and day in segregating the evidence so that no time should

be lost in presenting the details of the Pacific Coast abortion racket to the San Francisco grand jury.

On June 18, 1936, indictments charging violating the provisions of Section 274 and Subdivision 1 of Section 182 of the Penal Code of California were brought by the San Francisco grand jury against the following asserted principals and associates in the Pacific Coast abortion ring: Nedra Arden (nurse), Dr. James Beggs, Beatrice Bole, asserted solicitor; William A. Byrne (former investigator for Medical Board); Grace Cole, receptionist; John A. Creeth, secretary Medical Acceptance Corporation; Paul de Gaston, Josephine Follett, L. J. Giubbini, D. C., Leola Habel (Sarah L. Lee), office nurse; Ruth Hansen, Dr. Harry L. Houston, Gladys Korf, Bessie McCarthy, Zora McEwen, Laura Miner, Dr. E. T. Patee, Violette Pellegrini (Violet Brown), J. C. Perry, San Francisco office Medical Acceptance Corporation; Dr. William Norman Powers, Reginald L. Rankin, Violet Rankin, Marvin Raithel, Dr. Jesse C. Ross, Dr. (A. H.) Valentine St. John, J. O. Shinn, Medical Acceptance Corporation; Dr. F. B. Smith, Viola Warner, Dr. George E. Watts, Lillian Wilson, Mary Wilson. Warrants for their arrest were issued.

Assistant District Attorney McMahon, Captain Charles Dullea with Inspectors George Engler and Harry Husted daily pored over the accumulated evidence.

Seattle police reported the apprehension of L. J. Giubbini and Violette Pellegrini as they disembarked from a steamer on which, assertedly under the name of Dr. and Mrs. Victor Angelo, they had completed a cruise to Alaska. Away went Assistant District Attorney McMahon and Inspector Engler to Seattle, fortified with extradition papers for the return of the fugitives. Although the Seattle authorities had been requested to hold the fugitives until the arrival of the San Francisco authorities, the latter found the "birds had flown" before their arrival. However the trip was not in vain, for while in Seattle they obtained a most valuable signed statement from Paul de Gaston (indicted), who later testified for the prosecution in the Los Angeles trials.

District Attorney Buron Fitts of Los Angeles joined in the chase of those connected with the Pacific Coast abortion ring. He assigned his deputy, Verne Ferguson, to the task of cleaning up this racket. He came to San Francisco with two investigators of the Los Angeles Police Department, made some special investigations, went over the evidence accumulated by the San Francisco authorities. Thereafter on August 27, 1936, the Los Angeles grand jury returned indictments against the following individuals associated in the Pacific Coast abortion racket: Dr. James A. Beggs, Beatrice Bole, William A. Byrne, Grace Cole, John A. Creeth, Dr. Harry Houston, Bessie McCarthy, Grace Moore, Violet Pellegrini, J. C. Perry, Dr. William Norman Powers, Jessie Radcliffe, R. L. Rankin, Dr. Jesse C. Ross, Dr. (E. H.) Valentine St. John, J. O. Shinn, Dr. George E. Watts, Lillian Wilson.

All those indicted either surrendered to the authorities or were apprehended, excepting Beatrice Bole and Dr. Harry Houston, who at last accounts were still fugitives from justice.

Following conferences between the representatives of the district attorneys of San Francisco and Los Angeles it was agreed the trials be held in Los Angeles, the headquarters of the racket. It was also agreed that San Francisco Assistant District Attorney John McMahon was to assist Los Angeles Assistant District Attorney Verne Ferguson in the prosecution of those indicted.

Came the day of trial. Some fourteen indicted individuals, with a battery of five defense attorneys, appeared before one of California's most learned and fearless judges, Honorable Arthur Crum.

An editorial headed "Breaking Up of Criminal Abortion Syndicate," published in the *Bulletin* of the Los Angeles Medical Association, November 6, 1936, stated: "... At the beginning of the trial it appeared that 'jury fixers' were active. In order to keep the jury free from this influence the trial judge, Judge Arthur Crum, ordered the jury locked up during the trial. Later, upon evidence supplied by Mr. Ferguson that there was tampering with witnesses, Judge Crum, with commendable courage, ordered several of the accused held in the county jail during the period of the trial"

* Previously mentioned.

The prosecution required almost one month to present its testimony. The defense had but little to offer. Prosecution testimony sparked with sensational evidence as the prosecution, step by step, unwound the intricate workings of the racket. How the internal revenue income tax experts must have sharpened their pencils after hearing the fabulous revenue derived from the abortion business! Testimony of representatives of certain banks, depositories for the R. L. Rankin Company, the Medical Acceptance Corporation and R. L. Rankin disclosed unbelievable transactions. Representatives of the Western Union Telegraph Company testified they had transported sums of money to Rankin. Assistant District Attorney Verne Ferguson was quoted in the *Los Angeles Herald Express*, October 15, 1936, as stating he would prove that many thousands of the \$1,000,-000 he claims the syndicate made in 1935 was sent to Rankin by wire. Laura Miner was quoted in the *Los Angeles Evening News*, October 15, 1936, as testifying that a year previous William Byrne, one time investigator for the Medical Board, threatened her with arrest if she did not join the syndicate; how she had been placed in charge of the San Diego office on salary; how she had been instructed by Rankin as to the bookkeeping system to be followed in all offices; how and where she remitted revenue to Rankin; how she received weekly salary checks, signed R. L. Rankin, by J. L. Shinn, and how later she assertedly was "strong armed" by Rankin into buying the San Diego office. "She introduced in court six \$1,000 checks she said she had been forced to give to 'the boys' for 'protection'." She said after being coerced into joining the "ring," she was later forced to buy back her own business for \$30,000.

Bernice Tieman, former nurse in the San Jose office of the abortion syndicate and witness for the prosecution, was quoted in the *Los Angeles Examiner*, October 21, 1936, as testifying, "Mr. Rankin told me after the raids on the clinic last June, that they would get rid of me if I turned State's evidence." Paul de Gaston (heretofore mentioned on page 12), a prosecution witness, testified that although he was not licensed to practice medicine anywhere in the United States, he was employed by the ring at a salary of \$750 a month, eventually opening branches for Rankin in Seattle and San Francisco; that he was furnished with licenses, making it appear he was a duly licensed physician; that in San Francisco (2240 Van Ness Avenue), he hung on the wall of his office a framed license for a "Dr. Hoschi." (According to San Francisco Police Department, this was a license in the name of Dr. Jacob F. Hosch, licensed in Oregon, but not in California.) De Gaston testified that he operated under that name and that in Seattle he used the name Dr. T. F. Read to conform with a certificate furnished by Rankin bearing that name. (*Hollywood Citizen News*, October 9, 1936.)

Mrs. Gladys Duckworth, prosecution witness, testified that prior to the trial Rankin and William A. Byrne called on her and worked on her sympathy. "Mrs. Miner said that Rankin and Miss Elsa Timler (Timmer), friend of Byrne, asked her 'not to remember' certain testimony." (*Los Angeles Evening News*, October 9, 1936.) This evidence, as well as similar testimony by Nedra Cordon (also known as Nedra Arden) and Dr. W. Norman Powers, caused Superior Judge Crum to revoke the bail of Byrne and Rankin, who were then ordered into custody of the sheriff during the remainder of the trial. (*Los Angeles Examiner*, October 9, 1936.)

On October 24, 1936, the jury brought in the verdicts as follows: Dr. James Beggs, William A. Byrne, Grace Moore, Reginald R. Rankin, Dr. Jesse C. Ross, J. O. Shinn, Dr. George E. Watts, and Lillian Wilson were found guilty on five counts; Violetta Pellegrini was found guilty on three counts; John Creeth and Dr. (A. H.) Valentine St. John, were found guilty on two counts; and Dr. William Norman Powers, plead guilty to one count.

Thereafter sentences (to run consecutively, not concurrently) were imposed by Superior Judge Crum as follows: Dr. James Beggs, William A. Byrne, Reginald Rankin, Dr. Jesse C. Ross, and Dr. George E. Watts, were sentenced to ten to twenty-five years in the penitentiary. Dr. (A. H.) Valentine St. John was sentenced to state prison for a term of four to ten years. John Creeth and J. O. Shinn were given five years' probation, without requirement that they serve any time in jail. Dr. William Norman Powers, who testified for the prosecution, was

sentenced to state prison, which sentence was suspended and he was put on probation for three years, which includes a condition that he spend six months in the Los Angeles County jail and shall not practice medicine during the period of his probation, but may return to the State of Washington following completion of his jail term. Violet Pellegrini was given probation on condition she serve one year in the Los Angeles County jail. Lillian Wilson and Grace Moore were also given probation, on condition they serve six months in the Los Angeles County jail. Defendants J. C. Perry and Mrs. Jesse Radcliffe were acquitted. According to the *Los Angeles Herald Express*, November 6, 1936, Dr. (A. H.) Valentine St. John, a British born naturalized citizen of Rumania, may be taken from state prison after a year and deported. Beggs, Byrne, Rankin, Ross, St. John, and Watts have filed notice of appeal.

So endeth the Pacific Coast abortion ring—"Up like a rocket and down like a stick." Its doctors dropped with a sickening thud from an income of about \$1,000 per month to the squalid fare of a state prison.

Said the "Bulletin of the Los Angeles Medical Association" in its issue of November 5, 1936, under the heading "Breaking Up of Criminal Abortion Syndicate":

The criminal abortion syndicate which flourished in California during the last few years has been broken. In the Superior Court of Los Angeles County the members of this syndicate have been convicted of criminal conspiracy. This syndicate operated a racket which had no parallel. In its operation there were banded together a group of heartless promoters, doctors, nurses and public officers, who believed themselves above the law and without danger of being attacked. To Dr. Charles B. Pinkham, Secretary of the State Board of Medical Examiners, to the District Attorney of San Francisco County and to Byron Fitts, District Attorney of Los Angeles County, goes credit for the indictments that brought the members of this syndicate to trial. Early in the investigation Mr. Fitts assigned Mr. Verne Ferguson to full time on the case. To Mr. Ferguson and Mr. McMahon (Assistant District Attorney of San Francisco) is due the major credit for the exhaustive investigation which brought so complete a presentation to the jury that convictions were obtainable . . . The citizens of this state and particularly the medical profession, should feel deeply grateful that our law enforcement officers have been alert and have done an excellent bit of work in clearing up what was fast becoming a disgraceful condition—a condition which struck deeply into the finer standards and ideals of our profession.

CALIFORNIA INFANT MORTALITY RATES*

Adjusted for California Residence

Infant mortality rates have long been recognized as a most sensitive index to actual public health conditions within the community. Because of the fact that births and deaths of infants often occur in places other than those constituting the true place of residence of the mother, it has been difficult, in the past, to secure a reliable record of infant mortality in the various communities of California. Through the use of a Works Progress Administration project, adjusted infant mortality rates have been made for the years 1934 and 1935; such adjustments covering the rural districts and the incorporated cities within each county of the State.

In those cities where the county hospital is located within a large center of population, that city's infant mortality rate is conspicuously high because many infants are brought from the rural districts of the county into the city where death occurs. Similarly, in those counties where the county hospital is outside of the incorporated limits of any city, the infant mortality rate for the rural district is excessive.

It should be understood that, in this work, the births in these communities were adjusted for residence and the deaths as well. The adjusted infant mortality rates, therefore, provide a true index to infant mortality in these communities during the two years covered by the project. The rates for the State as a whole are changed slightly due to adjustments caused by residence outside of the State.

* Reprinted from California State Board of Health Bulletin.

The following table provides the crude and adjusted numbers of infant deaths, with rates for 1934 and 1935:

Adjusted Infant Mortality Rates, 1934 and 1935
By California Counties and Cities

	1934		1935	
	Crude No. Rate	Adjusted No. Rate	Crude No. Rate	Adjusted No. Rate
California	4047 51.6	4026 51.5	3973 49.5	3958 49.5
Alameda	13 48.3	23 63.2	14 50.4	21 53.8
Oakland	164 40.5	136 41.2	171 41.7	131 38.9
Alameda	5 15.0	12 38.1	2 7.3	9 27.4
Berkeley	22 35.2	20 22.4	23 31.8	36 41.0
San Leandro	2 21.0	10 54.6	4 44.9	9 47.1
Albany	3 20.2	1 7.8	11 51.6	5 33.5
Hayward	6 73.2	9 65.7	5 52.1	15 92.2
Piedmont .....	.....	1 14.9	.....	.....
Alpine .....	.....	.....	.....	.....
Amador	2 52.6	4 56.3	2 26.0	5 41.7
Butte	20 56.3	21 54.5	19 54.6	19 50.3
Chico	7 30.5	6 34.1	13 50.4	13 71.0
Calaveras	1 12.5	1 10.9	.....	.....
Colusa	11 64.0	11 60.8	10 61.0	10 58.1
Contra Costa	17 51.6	25 40.3	16 48.0	28 43.9
Richmond	9 32.5	9 32.6	14 52.2	13 42.5
Martinez	11 47.2	6 53.1	17 62.0	4 33.6
Pittsburg	5 35.2	9 51.7	5 36.8	11 57.0
Del Norte	4 63.5	4 70.2	2 27.4	1 14.5
El Dorado	2 16.8	3 21.1	3 28.3	5 39.1
Fresno	163 98.7	139 101.4	98 54.2	87 60.2
Fresno	30 51.3	49 54.9	32 46.6	42 41.2
Glenn	9 67.6	10 61.7	8 52.6	10 52.3
Humboldt	9 35.4	19 47.4	13 50.6	19 47.3
Eureka	16 45.7	8 40.2	18 47.6	15 64.4
Imperial	111 152.0	101 134.5	65 103.8	56 85.0
Brawley	67 186.1	72 209.3	59 150.9	62 161.0
Calexico	16 75.8	18 116.9	12 72.7	13 78.2
El Centro	12 74.5	19 107.3	6 35.9	14 78.2
Inyo	1 14.1	1 13.9	7 106.1	7 93.3
Kern	90 84.6	82 76.2	109 101.1	90 80.4
Bakersfield	19 36.2	23 43.4	31 54.7	50 89.3
Kings	35 129.1	34 116.0	26 89.6	29 85.3
Hanford	9 45.2	11 55.3	20 86.9	17 88.1
Lake	4 54.0	4 49.4	2 24.4	5 52.1
Lassen	17 73.3	17 72.3	13 56.3	14 59.6
Los Angeles	164 36.0	229 53.6	147 31.4	232 49.4
L. A. City	910 52.6	777 45.4	880 52.1	683 40.9
Alhambra	9 41.6	14 35.3	7 31.5	11 30.2
Long Beach	64 30.9	59 32.0	83 38.0	78 39.1
Pasadena	22 32.7	23 26.7	12 17.6	15 19.1
Pomona	11 33.9	10 37.5	16 49.4	20 63.3
Santa Monica	26 36.8	33 73.2	22 28.6	34 71.3
Glendale	29 28.7	36 51.1	23 23.3	32 46.5
Monrovia	2 24.1	3 26.1	2 23.8	6 45.8
Redondo Beach	1 21.7	2 13.8	3 54.5	7 43.5
Whittier	13 42.5	13 54.6	18 60.0	25 123.8
So. Pasadena .....	.....	2 20.4	1 125.0	2 20.0
Arcadia	2 142.8	2 31.7	1 71.4	2 36.4
Bell	7 24.5	10 69.0	9 19.9	10 57.1
Beverly Hills	1 250.0	2 13.1	2 333.3	3 17.3
Burbank	4 26.6	7 25.4	7 40.0	9 35.7
Compton	15 73.1	17 62.5	9 41.9	11 44.3
Culver City	1 7.9	5 45.9	3 25.0	5 43.8
Hawthorne	2 18.2	4 34.2	7 51.1	8 63.0
Hunt'ton P'k	13 31.8	17 45.1	15 44.9	19 57.0
Inglewood	9 25.5	10 34.2	10 23.9	13 49.8
Lynwood	1 37.0	2 14.7	2 90.9	6 43.5
Maywood	1 28.5	4 29.0	1 14.3	2 15.3
Montebello	2 39.2	4 35.7	3 142.8	10 91.7
Monterey P'k	4 27.4	5 67.6	6 33.7	8 94.1
San Fernando	14 105.2	17 90.4	10 83.3	17 87.2
San Gabriel	6 120.0	8 46.0	1 23.8	7 42.7
South Gate	6 15.4	10 26.6	10 26.8	14 40.9
Torrance	3 13.3	6 35.9	2 8.2	8 47.0
Madera	22 75.3	24 79.2	29 105.4	30 100.3
Marin	56 50.0	11 38.5	1 7.6	6 21.0
San Rafael	4 26.3	3 40.0	6 41.9	5 48.5
Mariposa	1 21.3	1 14.3	2 60.6	2 29.8
Mendocino	19 66.6	20 67.3	11 35.2	13 40.5
Merced	39 78.9	33 65.0	34 69.8	32 67.2
Merced	10 70.4	18 135.3	7 36.8	11 52.9
Modoc	3 37.0	4 50.6	8 88.9	9 92.7
Mono .....	.....	.....	1 142.8	1 71.4
Monterey	39 81.7	40 90.7	35 61.8	25 54.7
Monterey	7 50.3	8 46.8	6 66.7	8 60.1
Pacific Grove	3 30.9	2 24.7	3 56.6	5 61.0
Salinas	6 33.7	9 39.3	7 35.3	13 45.8
Napa	11 72.8	10 77.5	4 34.2	3 29.1
Napa	9 75.0	9 78.9	4 32.8	5 44.6
Nevada	11 67.0	11 69.2	19 84.4	18 80.3
Orange	90 106.9	74 76.8	71 88.4	69 72.9
Santa Ana	12 32.9	26 62.3	28 66.5	33 70.2
Anaheim	14 115.7	20 102.6	5 39.4	8 39.0
Fullerton	4 24.4	3 22.7	4 23.4	5 37.9
Orange	14 47.3	10 70.4	17 47.1	14 86.9
Placer	11 49.3	11 45.8	12 57.7	13 56.0
Roseville	6 92.3	6 61.2	2 37.0	3 33.3
Plumas	6 60.0	6 57.7	2 21.5	2 19.8
Riverside	61 93.1	77 94.4	59 86.1	70 79.6
Riverside	42 68.2	30 57.7	33 42.8	23 42.7
Corona	13 74.3	13 74.3	7 42.7	8 38.5
Sacramento	9 40.0	32 50.1	9 42.6	26 38.6
Sacramento	78 42.5	48 39.8	101 52.2	74 57.3
San Benito	11 75.3	8 50.6	14 107.7	13 86.1
San Bernardino	42 52.7	48 55.9	43 47.2	46 42.2
Redlands	8 38.1	10 46.1	11 46.6	16 76.9
San Bern'dino	66 73.3	41 60.3	69 69.9	45 64.0
Ontario	5 42.3	12 55.8	9 58.1	17 68.8
Colton	13 76.9	16 80.0	10 61.3	20 98.0
San Diego	29 67.7	48 63.4	18 44.7	25 31.9
San Diego	120 46.9	101 43.3	111 38.7	95 38.4
Coronado	4 74.0	6 63.8	2 37.7	3 28.3
National City	16 44.3	13 77.8	11 49.5	6 34.1
San Francisco	237 33.1	214 32.6	251 35.2	217 33.4
San Joaquin	49 63.6	45 73.0	67 81.6	41 61.6
Stockton	29 53.9	38 55.9	34 55.3	54 74.4
Lodi	4 28.8	3 21.7	4 27.8	10 69.0
San Luis Obispo	3 16.6	9 31.2	10 51.8	22 75.3
S. L. Obispo	12 47.0	8 53.3	19 78.2	10 66.2
San Mateo	5 63.3	12 31.1	2 41.7	8 24.6
San Mateo	22 46.9	6 40.3	13 32.9	6 42.2
Burlingame .....	.....	3 21.6	1 333.0	5 35.7
Daly City	1 52.6	6 54.0	.....	5 47.2
Redwood City	1 23.2	7 51.1	1 24.4	3 23.1
So. San Fran.	2 38.4	6 77.9	1 17.5	1 12.2
Santa Barbara	37 122.5	29 75.5	16 45.4	29 77.7
S. Barbara	21 43.1	38 73.5	22 46.5	19 33.4
Santa Maria	23 80.1	12 71.4	21 73.9	7 42.2
Santa Clara	62 49.9	31 37.6	91 70.9	48 53.1
San Jose	10 19.0	30 35.4	15 29.0	48 66.7
Palo Alto	6 22.1	6 29.7	7 27.2	4 22.6
Santa Clara .....	.....	4 51.9	1 47.6	9 93.7
Santa Cruz	8 58.0	10 55.9	5 37.0	9 68.7
Santa Cruz	10 47.4	11 60.8	6 35.7	6 35.9
Watsonville	8 38.8	6 27.5	16 72.4	13 54.8
Shasta	9 39.3	8 32.9	14 55.1	15 56.0
Sierra .....	.....	2 57.1	2 57.1	2 45.4
Siskiyou	18 52.3	17 49.7	18 52.8	19 56.0
Solano	7 40.0	6 28.7	10 52.3	8 37.4
Vallejo	9 40.3	9 35.8	11 49.5	15 57.9
Sonoma	25 70.4	24 52.7	19 55.9	19 43.9
Petaluma	8 56.3	5 61.7	3 20.8	2 22.0
Santa Rosa	4 21.5	9 54.5	7 35.2	8 47.9
Stanislaus	19 39.5	22 49.5	20 40.1	37 53.0
Modesto	38 78.3	22 78.8	31 55.6	15 50.3
Sutter	18 78.6	16 70.2	18 65.0	17 64.1
Tehama	11 51.4	8 41.0	7 31.2	8 36.7
Trinity	1 30.3	1 21.7	2 43.5	2 33.9
Tulare	72 67.8	74 72.4	83 74.0	80 71.4
Visalia	8 44.2	10 57.8	8 42.5	9 53.2
Porterville	7 56.0	8 56.3	10 68.5	11 79.1
Tulare	10 112.3	13 99.2	10 91.7	15 97.4
Tuolumne	6 57.7	6 56.1	8 75.5	8 73.4
Ventura	47 95.9	31 59.8	48 92.1	40 78.6
Oxnard	25 95.0	33 201.2	20 77.5	19 97.9
Santa Paula	9 66.6	12 67.0	5 39.1	11 59.8
S. Bue'v'n'tra	4 18.7	12 46.9	3 19.5	9 44.1
Yolo	10 70.9	10 44.0	10 62.5	15 59.3
Woodland	3 21.6	2 18.2	3 20.3	3 28.8
Yuba .....	.....	2 16.7	2 41.7	5 54.3
Marysville	11 70.9	11 90.2	11 84.6	10 91.7

**TWENTY-FIFTH ANNIVERSARY OF THE
CHILDREN'S BUREAU, UNITED STATES
DEPARTMENT OF LABOR***

A Quarter Century of Work for Children

By KATHARINE F. LENROOT

Last summer there came to my desk a letter that made me realize not only that the Children's Bureau had come of age some time before, but that those of the staff who, like myself, had been associated with it almost from the beginning, were truly of the "grandmother" class. The letter read in part as follows:

I am writing you to see if I can get some booklets on Infant Care before and after birth.

I recently found an Infant Care book from which I was raised and which was published July, 1914, so that is where I am getting my information to write to you.

The incident led to rummaging in our own attic, the files of the Children's Bureau, for some of the letters that came to Julia C. Lathrop, the Bureau's first chief, in those earliest years. Here is one from a little girl named Kathryn, who wrote to "Uncle Sam" asking him please to "send me a baby brother whenever you have any." In her thoughtful and characteristically human reply, Miss Lathrop wrote:

I wish we had a baby brother to send to such a good home as I am sure he would find in your parents' house,

* Reprinted from "The Child," March, 1937. This issue of the Monthly News Summary of the Children's Bureau presented a frontispiece photo-cut of Grace Abbott, Chief of the Children's Bureau, 1921-1934, giving the following excerpt from one of her addresses:

"If there is any subject endowed with national interest, it is the welfare of the nation's children. The nation's future existence, the intelligent use of its resources, the rôle it will play in world affairs, depend on its children—whether or not they are physically fit and whether or not they are trained in self-control, in respect for the rights of others, and in understanding of their own rights and obligations. That the first responsibility must rest with the nearest government—the State, the county, and the municipality—is the reason why the rôle that the Federal Government must play in the training of children is that of an intelligent and interested coöperator, ready to assist but not to control nor hamper."

but Uncle Sam does not trust us with real babies, but only tells us to try to learn all the ways to keep babies and their older brothers and sisters well and good and happy. This is hard, slow work, and sometimes I feel a little discouraged because it is so slow. Your letter cheers me up and I am glad you wrote, although I am obliged to send this disappointing answer.

When this letter was written, in 1914, as described in another article in this issue, there was no national birth-registration system in the United States. One of the first tasks to which Miss Lathrop set the Children's Bureau, in cooperation with the Bureau of the Census, the General Federation of Women's Clubs, and other agencies, was the development of the United States birth-registration area, which did not cover the entire country until 1933. In twenty-nine years, from 1915 to 1935, the infant mortality rate has been cut almost in half, although the loss of life in the first month of infancy has been reduced very much less, and now constitutes more than one-half the total loss of life in the first year. Very slow progress has been made in reducing the appallingly high death rate among mothers, which early gave Miss Lathrop grave concern. In 1916 she wrote as follows to a mother in Wyoming, who had described the deaths of two mothers and two babies in her own sparsely settled rural community within a year:

Your letter of October 19 came in my absence, and I have just read it with most urgent attention and sympathy. It is not the only letter of that kind which the Bureau has received—it makes very urgent the great question of protecting motherhood. The Bureau is trying to find a plan by which mothers living in remote places can secure the medical and nursing care to which they are certainly entitled. It is an old need, but a new practical question, and it will not be solved until many people can be made to see that a way to provide the required care is possible in every part of our country.

In 1917 Miss Lathrop set forth in her annual report a program for the protection of maternity and infancy, of which the principal features were as follows:

1. Public health nurses who shall be available for instruction and service as are the public school teachers and other public officers;
2. Instruction in schools and universities and through different forms of extension teaching covering the field of hygiene for mothers and children, furnished at such places and times as to meet the needs of persons of varying ages and circumstances;
3. Conference centers at county seats or elsewhere, affording convenient opportunity to secure examination of well children and expert advice as to their best development;
4. Adequate confinement care;
5. Hospital facilities made available and accessible for mothers and children.

From 1922 to 1929 under the Sheppard-Towner Maternity and Infancy Act progress was made in developing public-health nursing, prenatal and child-health conferences, and health-education services throughout the United States. With the termination of the act and consequent withdrawal of Federal aid, just at the onset of the depression, these services were greatly curtailed.

The passage of the Social Security Act, approved August 14, 1935, made possible a vigorous program to safeguard and promote the health of mothers and children through the coöperation of the Federal Government, the states, and the local communities. Summary of state plans submitted this year by the fifty-one states and territories co-operating with the Children's Bureau under the act shows great extension of resources for bringing mothers under early prenatal care, for child-health clinics and conferences, for immunization against communicable disease, and for public health nursing services in the home. In many areas opportunities for post-graduate instruction in obstetrics and pediatrics have been brought to doctors in their own communities.

Evidence is steadily accumulating that a direct and courageous attack must be made on the central problem of providing adequate medical and nursing care at time of delivery, with medical and nursing supervision continuing throughout the antenatal and postnatal periods. Such care would conserve the lives not only of the mothers but also of many thousands of the new-born, and those who die before birth. It can be provided only with the coöperation of Government, practicing physicians, nurses, professional schools, and the mothers and fathers themselves. The

American Committee on Maternal Welfare is coöperating with the Children's Bureau in considering the various steps which will be necessary if motherhood in America is to be given safeguards commensurate with the need and the possibilities of saving life and health.

Care of the mother and the new-born infant is of primary importance, but many and varied are the needs of youth in the period from infancy to maturity. The real basis of progress in safeguarding the health and general welfare of the Nation's children lies in a threefold program: Correction of existing conditions that stand in the way of the child's wholesome development; prevention of such conditions; and above all, general application of knowledge of those conditions that will enable children everywhere to be born, to grow, and to develop according to standards that will give them their fair chance in the world.

Changing conditions of national life, emergencies such as those that occur in periods of depression and widespread unemployment, new discoveries resulting from the advances of science, and the needs of special groups at different times may require emphasis to be placed on one or another of the varied factors contributing to child welfare. However, each factor must be weighed in relation to all the others, for the welfare of the child as a whole is like a fabric woven of many different threads.

Immediate responsibility for the welfare of children lies with their families and their home communities. If there is one fact more than any other that has emerged from all the studies of the Children's Bureau, it is that the primary essential of child welfare is the power to maintain a decent family living standard, and this is dependent upon many factors not within individual control. In other words, the problem of economic security is a vital part of the whole problem of child welfare. Measures tending to promote economic security, such as an adequate wage level, good housing at reasonable cost, unemployment compensation, prevention of accidents and sickness, and care of the incapacitated breadwinner and his family, are basic factors in the well-being of children. They should be accompanied, however, by measures for parental education in methods of child care, and organization of community services for child health, child protection, and the care of children who are dependent, neglected, delinquent, or handicapped in body or mind.

Elsewhere in this issue has been related the progress which has been made in a period of twenty-five years in dealing with problems of child labor, juvenile employment, and the development of community resources for children. In one special type of need—provision for the crippled child and the care of those conditions which may lead to crippling—a definite program of Federal and state coöperation is being carried on under the Social Security Act, with forty-five states and territories developing or extending services to crippled children under its provisions. This first experience in Federal aid to the states for medical care of children should provide a sound foundation of relationships and methods upon which to build services for other types of handicapped children as their need for Federal assistance may be disclosed.

In twenty-five years, in comparison with the problems to be solved and the needs to be met, the work of the Children's Bureau as a broadly conceived center of information and service in all phases of child life has just begun.

By its thirty-fifth birthday the Bureau should be able to report:

1. Reduction of the death rate per 1,000 live births in the first year of life from 56 to 35 or below; in the first month of life from 34 to 24; reduction of the stillbirth rate from 36 to 26 or below.
2. Reduction of the maternal mortality rate per 10,000 live births from 58 to 38 or below.
3. Practical elimination, through immunization, of smallpox and diphtheria, great reduction through more widespread use of measures now available or being developed in the number of deaths of children from whooping cough, measles, scarlet fever, and pneumonia; reduction in congenital syphilis through the syphilis program being stimulated by the United States Public Health Service; definite progress in control of epidemics of infantile paralysis, and in the prevention of crippling conditions resulting from this disease; prevention of and care for injuries to new-born infants.
4. Marked reduction in the number of undernourished children through improved economic conditions and widespread dissemination among the people of knowledge of

ways in which good nutrition may be assured at moderate cost.

5. Elimination of child labor under the age of 16 years and safeguards of employed youth 16 and 17 years of age in industrial and commercial occupations and other occupations where children and their parents are especially subject to commercialized exploitation, through direct Federal legislation, administered in cooperation with State agencies, made possible by completion of the ratification of the child labor amendment.

6. Widespread extension of educational and vocational guidance and junior placement service, built upon elementary and secondary school facilities and facilities for public recreation increasingly adequate to meet the needs of youth in a period of rapidly accelerated economic and social change.

7. Increased availability to rural as well as to urban children of public assistance when the economic ability of the normal breadwinner to provide for his family fails, and of case work, child guidance, recreational, and other community services for the early discovery and remedial treatment of conditions leading to child dependency, neglect, emotional instability, and delinquency.

8. Extension of services to crippled children, to include all physically handicapped children not otherwise able to obtain skilled medical, surgical, nursing, and social care, these programs being closely correlated with a sound program of education and guidance adapted to the needs of each child.

9. Development of comprehensive state-wide and community programs for the care of the mentally deficient, including discovery, diagnosis, special class education, community supervision, and for those who need it, institutional or boarding home care.

10. Changed public attitude toward juvenile delinquency, based upon increasing awareness of the conditions leading to its development and the types of service in community, court, and training school which are essential if children thwarted and handicapped by untoward family and neighborhood conditions from their earliest years are to be given their fair chance in the world.

These are far-flung goals, but they are not beyond the knowledge and the resources which can be made available within the next ten years to those responsible for the health and welfare of American children. To achieve them, there must be assured the earnest cooperation of parents, schools, men's and women's civic organizations, public officials of localities and states, and the resources and leadership of the Federal Government.

As Grace Abbott has often said, what we would do for children this year cannot be postponed until next year, for children do not wait upon convenience. They live and thrive in proportion as we are understanding, loving, and resourceful in their service.

HOSPITAL INSURANCE*

Two months ago the San Francisco County Medical Society invited the Insurance Association of Approved Hospitals (Alameda Plan), to enter San Francisco for the purpose of selling hospital insurance. It has taken two months for the Hospital Conference to approve the Insurance Association of Approved Hospitals plan, but this was done on March 11, 1937, and by the time the "Bulletin" reaches you it is expected that many of the hospitals of San Francisco individually will have signed the contract.

The provisions of the plan as presented to prospective insureds are outlined below:

"In the event of sickness or disability through injury, expense results. Should hospitalization be necessary, a membership in this Association entitles you to the following service in one of the participating hospitals, while it in no way disturbs the relationship between your doctor and yourself. You make your own selection of physician or surgeon and pay him direct for his services.

Service covered by this membership includes:

Board and room—Ward accommodations. (Should a private room be desired, this may be obtained by paying the difference in rate directly to the hospital.)

General nursing care.

Operating-room service, including anesthesia if given by hospital employee.

Material appliances, such as splints, casts, etc.

Dressings.

Physiotherapy treatments.

Drugs and medicines, with the exception of serums, vaccines, spirituous liquors and expensive proprietary drugs.

The Association will indemnify the patient to pay the pathologist for routine clinical laboratory services, i. e., urinalysis, complete blood count, coagulation time, smears.

Indemnify the patient to pay the roentgenologist for the following services:

(a) In cases of accidental bodily injuries, all such services necessarily incident or required, exclusive of therapy, in the opinion of the attending physician, for the registered hospital bed patient.

(b) In cases of bodily illness or disease only when necessary to assist in diagnosis during hospitalization, and expressly excluding all therapy and any diagnostic services which could have been performed prior to admission to the hospital.

Membership covers hospitalization for twenty-one days for any one illness or accident during any twelve-month period.

If traveling, should you suffer an injury or sudden illness necessitating hospitalization, you will be provided with fourteen days' service in any accredited hospital in the United States or Canada.

Hospital service becomes effective:

1. For accidental injury—one day after application has been accepted.

2. For sickness or illness contracted or having its first signs or symptoms more than seven days after application has been accepted.

3. For illness or ailment requiring major or minor operation that is contracted or has its first signs or symptoms more than fifteen days after application has been accepted, except in the case of hernia, tonsillectomy or adenoidectomy which is twelve months after application has been accepted.

Services not provided in this contract are:

Tuberculosis, diagnosed cancer, venereal infection, mental disorders, occupational diseases or injuries covered by law, alcoholism, drug addiction, rest cure, intentional self-inflicted injuries (sane or insane), normal pregnancy, including cesarean section, abortions or services of special nurses.

Applicant must be in good health at time of application for membership and between eighteen and sixty-five years of age, but no medical examination is required. Hospitalization of any member must be upon the written order of a legally qualified doctor of medicine, whose credentials would be recognized by hospitals accredited by the American College of Surgeons.

Dues.—The rate per month shall be 90 cents per member, paid in advance; plus a registration fee of \$1, which must be paid at the time of filing application. Members will receive the same attention and courtesy in the hospital as if they were paying the bills personally.

Service covered by this contract is confined strictly to the care of registered hospital bed patients."

GERMAN MEASLES

Regulations of the California Department of Public Health for the Prevention of German Measles

At a recent meeting, the State Board of Public Health amended Rules 5 and 6 of the state regulations for the prevention and control of German measles. The complete regulations now read as follows:

Rule 1. Notification

Any person in attendance on a case of German measles, or a case suspected of being German measles, shall report the case immediately to the local health authority, who shall in turn report at least weekly, on the prescribed form, to the Director of the State Department of Public Health all cases so reported to him.

NOTE.—The report to the local health authority shall be in writing unless local rules permit notification by telephone.

When no physician is in attendance it shall be the duty of the head of the private house, or the proprietor or keeper

* Reprinted from the "Bulletin" of the San Francisco County Medical Society.

of any hotel, boarding house, lodging house or superintendent of any orphanage or school to report forthwith to the local health officer all the facts relating to the illness and physical condition of any person in any private house, hotel, boarding house, lodging house, orphanage or school under his charge who appears to be affected with any disease presumably communicable, together with name of such person.

Rule 2. Instructions to Household

It shall be the duty of the physician in attendance on any case suspected by him to be German measles to give detailed instructions to the nurse or other person in attendance in regard to precautionary measures for preventing the spread of this disease.

Rule 3. Investigation of Cases

Upon being notified of a case of German measles, the local health authority shall make an inquiry regarding the probable source of infection. If this source of infection is outside his jurisdiction, he shall notify the State Department of Public Health in order that it may inform the health authority (local or state) within whose jurisdiction the infection was probably contracted. The local health officer shall determine that the instructions are understood and observed and, in the event of non-observance, shall take proper legal steps for their enforcement.

Rule 4. Isolation

It shall be the duty of the local health officer to see that cases of German measles are properly isolated, and to define the area within which the patient and his immediate attendants are to be isolated. Without permit from the local health officer, no person shall carry, remove or cause to be carried or removed from any hotel, boarding house, lodging house or other dwelling, any person affected with German measles. Isolation in this disease is defined as that degree of detention necessary to insure non-contact with susceptible persons.

Rule 5. Contacts

When a person affected with German measles is properly isolated, members of the family or household are not subject to any restrictions.

Rule 6. Release from Isolation

The period of isolation shall be until clinical recovery.

Rule 7. Exclusion by School Authorities

It shall be the duty of the principal or other person in charge of any public, private or Sunday school to exclude therefrom any child or other person affected with a disease presumably communicable until such child or other person shall have been seen by the school physician or nurse, or shall have presented a certificate issued by the local health officer, or by the attending physician, and countersigned by the local health officer, stating that such child or other person is not liable to convey a communicable disease.

Rule 8. Disinfection

Concurrent Disinfection.—All discharges from the nose and mouth of the patient shall be immediately disinfected by boiling or shall be burned. Objects which may have been contaminated by the patient shall be disinfected before being removed to any place where they might become possible sources of infection. Clothing and bedding that have been contaminated by the patient, as well as the dishes used by the patient, shall be sterilized by boiling or immersion for twenty minutes in 2 per cent carbolic acid or liquor cresolis compositus.

Terminal disinfection shall consist of thorough cleaning by scrubbing and washing with hot water and soap of material on which and in which bacteria may find favorable conditions for prolonging life and virulence.—*Weekly Bulletin, California Department of Public Health.*

PSITTACOSIS IN CALIFORNIA: 1934-1935

The problem of the administration and control of aviaries has gradually resolved itself into a routine function of this department. The procedure involves three main factors: Registration, release, legband code numbers, and shipment of shell parrakeets.

REGISTRATION

Anyone engaged in selling, trading or bartering shell parrakeets, must obtain a certificate of registration from the State Department of Public Health. Senate Bill No. 516, Chapter 607, 1933, requires an annual fee of \$5 for such a certificate. This fee is payable July 1 of each year in the form of a money order or cashier's check.

According to figures compiled to date there are on record 1,721 aviaries representing approximately 65,255 shell parrakeets. The following table gives the distribution by counties:

Counties	No. of Aviaries	No. of Birds
Alameda	24	1,540*
Contra Costa	5	200*
Fresno	5	338
Glenn	1	30
Humboldt	3	21
Kern	8	121
Kings	1	6
Lake	1	10
Los Angeles	1,378	45,790*
Marin	4	219
Merced	2	11
Monterey	4	112
Napa	7	66
Orange	68	4,452
Riverside	19	1,903
Sacramento	20	645
San Benito	3	30
San Bernardino	35	2,114
San Diego	38	2,374
San Francisco	4	107*
San Joaquin	6	229*
San Mateo	2	70*
Santa Barbara	9	777
Santa Clara	22	458*
Santa Cruz	5	265*
Solano	2	55
Sonoma	9	168
Stanislaus	7	132
Tulare	7	430
Ventura	25	2,557
Yolo	1	25
	1,721	65,255

Some of the counties have been surveyed during this biennium. Such a survey was conducted in Los Angeles County with the assistance of the SERA. A summary of the survey follows:

Summary of Aviary Survey, Los Angeles County, 1934		
Private aviaries	1,145	
Less than 100 shell parrakeets		1,127
100 to 500 shell parrakeets		17
501 to 1,000 shell parrakeets		1
Over 1,000 shell parrakeets		—
Total shell parrakeets in private aviaries in survey	18,442	
Commercial aviaries	233	
Less than 100 shell parrakeets	233	
100 to 500 shell parrakeets		158
501 to 1,000 shell parrakeets		7
Over 1,000 shell parrakeets		1
Total shell parrakeets in commercial aviaries covered in survey	27,348	
Total aviaries surveyed		1,378
Total shell parrakeets in these aviaries	45,790	

As the above figures indicate, the bulk of the industry is concentrated in Los Angeles County with 1,378 aviaries out of a total of 1,721 located there. Only a small percentage of these aviaries has been tested, released and registered for carrying on the business of buying and selling shell parrakeets. A large proportion of the remainder is maintained for pleasure until such time as the owner wishes to dispose of the surplus stock.

RELEASE

Then, the aviary is subject to the regulations passed by the State Board of Public Health in May, 1935, which provide that at least two laboratory tests be made before an aviary may be certified and the birds released for sale.

The first test consists of mature birds—six months of age or over and represents 10 per cent of the entire stock, with not less than ten birds accepted for the test. The second test consists of immature birds—three to five months of age and represents 10 per cent of the entire stock, with not less than ten birds accepted for the test. An aviary may be subject to repeated tests if in the judgment of the State Department of Public Health there is any suspicion concerning the status of the birds.

The following is a tabulation of the laboratory tests done during the period January 1, 1934, to June 30, 1936:

* Surveyed during 1934-1936.

Laboratory Tests of Aviaries

Year	Total No. of Aviaries Tested	No. Positive	No. Negative
1934.....	193	48	145
1935.....	79 (new aviaries)	3	76
	47 (retests*)	1*	46*
1936.....	10 (new aviaries)	...	10
	14 (retests*)	...	14*

In 1934, 24 per cent of the aviaries tested proved positive; in 1935 the percentage dropped to 3.8 per cent and in the first six months of 1936 all the aviaries tested were negative for psittacosis.

When the stock in an aviary is infected with psittacosis as demonstrated by laboratory examination, the birds may either be quarantined or destroyed. Practically all positive aviaries have been destroyed. This undoubtedly reduces the number of sources of infection and might account for the few positives found in 1935. However, other factors may be involved—i. e., the cessation of indiscriminate exchange of breeding stock among aviary owners with a resulting improvement in breeding stocks; the reduction of the number of nestings (mass breeding), the general sanitary conditions improved and the question of being at the low level of the disease cycle.

If the laboratory tests are negative for psittacosis, then the aviary is released. The following table gives the released aviaries by counties:

Released Aviaries by Counties, July 1, 1936

County	No. of Aviaries
Alameda	9
Contra Costa	1
Kings	2
Los Angeles	135
Orange	3
Riverside	2
Sacramento	2
San Bernardino	8
San Diego	1
San Joaquin	1
San Mateo	1
Santa Clara	5
Santa Cruz	2
Stanislaus	1
Tulare	4
Ventura	1
Total	178

LEGBAND CODE NUMBERS

A total of 178 aviaries have been given a release after negative laboratory examinations. These aviaries must band their mature birds with a code number assigned to them by the State Department of Public Health. These code numbers consist of a letter and a number with a star between indicating laboratory release (i. e., A *70). This identification is used to protect the owner when shell parakeets are involved in cases of suspected psittacosis.

SHIPPING

The released registered aviaries are permitted to sell intrastate and interstate properly banded mature birds—eight months of age or over. For interstate shipments the United States Public Health Service requires a certificate issued by the State Department of Public Health. This certificate must be sworn to by the shipper before a notary public.

A tabulation of interstate shipments is presented by months for this biennium:

Interstate Shipments of Shell Parakeets

	1934	1935	1936
January	1,368	1,839	1,839
February	1,303	2,101	2,101
March	2,436	3,030	3,030
April	2,090	2,135	2,135
May	2,104	2,212	2,212
June	1,347	2,098	2,098
July	1,342	...	...
August	162	2,521	...
September	496	3,719	...
October	1,251	4,433	...
November	1,507	6,077	...
December	1,830	7,862	...
Totals	5,245	36,602	13,415

During the first six months of 1936 approximately 3,000 more birds were shipped than during the same period in 1935. This would indicate that control measures have not interfered with the economic phase of a public health problem.

*Retests—Previous tests done in 1934 or 1935. Total aviaries excluding retests 282 and 51 positives. Total birds autopsied 13,219 (1934 to July 1, 1936).

DOCTORS' HOBBY SHOW:
ALAMEDA COUNTY

What does a famous surgeon do with his spare time?

Sharpen his tools and count his surgical sponges?

Not always. Sometimes he ties flies against the day when he can get to the mountain streams to try his skill with the elusive trout.

Sometimes he carves bedsteads for his children, sometimes he haunts second-hand stores in search of old guns, sometimes he paces the sea shores in search of rare shells.

An idea of what doctors do with their spare time was given the general public on Saturday and Sunday, March 27 and 28, at the California College of Arts and Crafts, Broadway at College, in Oakland, when the Doctors' Hobby Show is opened to the general public.

A wide variety of exhibits was presented by the members of the medical fraternity in metropolitan Oakland, exhibits ranging from colored photography of the State of California to oil paintings and sculpture, from hand-tied flies to model airplanes.

Doctors Frank Bowles and E. N. Ewer demonstrated the cunning of their fingers and the extent of their patience in an exhibit of dry flies, all hand-made, some of them copies of standard American and English flies, some of them originals.

In addition to displaying the finished flies, the doctors showed the various steps taken in the construction of a fly tracing the process from the bare hook to the finished fly—not excluding the fish, appropriately stuffed and mounted, that may be caught, with good luck and better management.

Among the large exhibits was a bedroom set of carved wood, the work of Dr. Charles Mell who made it for his daughters and used persons of the nursery rhymes for his subjects. It included a twin bed set, a chest of drawers, a cedar chest and several plaques.

Other featured exhibits included a collection of old guns and pistols presented by Doctors C. A. Wills and Fletcher Taylor; a collection of rare stamps by Doctors Harry and Henning Koford; pipes by Dr. James Campbell; orchids by Dr. Michael Torrano; sea shells by Dr. Frank Baxter; model ships by Dr. F. S. Bascom; model airplanes by Doctor Chesebrough; arrowheads by Dr. L. Michael and archery, aviation and agricultural items by Doctors Warren B. Allen, Francis Shook, J. L. Lohse, and W. E. Mitchell, respectively.

In the art line there were books by Dr. Milton Shutes, Dr. S. H. Babington, and Dr. Frank Makinson, all authors of note; photography by Doctors H. R. Parker, W. W. Cross, G. Splithoff, Wilbur Calkins, Stanley Truman, N. Keeler, and Stanley Davis; painting by Doctors William Strietman, Charles Peters, Mark Emmerson; sculpturing by Dr. William Porter, charcoal drawings by Dr. Leland Taylor, and etchings by Dr. Paul Michael.

A list of the exhibitors follows:

Dramatics: Dr. Robert Glen.
Orchid Culture: Dr. Michael Torrano.
Horticulture: Dr. George Calvin.
Walnut Culture: Dr. John Luis Lohse.
Study of Navajo Indians: Dr. S. H. Babington.
Medical History: Dr. Frank Makinson.
Life of Lincoln: Dr. Milton Shutes.
Guns and Pottery: Dr. C. A. Wills.
Model Ships and Rug Making: Dr. Noble Logan.
Arrowheads: Dr. Luther Michael.
Archery: Doctors Warren Allen, and M. F. Frandy.
Etching, Pen and Ink, Tortise Shell Work: Dr. W. S. Porter.
Stamps: Dr. Henning Koford.
Astronomy: Dr. Kenneth Tattersall.
Photographic Exhibits: Doctors Wilbur Calkins, Stanley Davis, A. W. Henry, C. A. Splithoff, Harry Templeton, Stanley Truman, W. W. Cross, H. R. Parker, and Francis Shook.
Pastels: Dr. W. H. Strietmann.
Charcoal: Dr. Leland Taylor.
Etching: Dr. Paul Michael.
Cabinet Making: Dr. Burton Adams.
Wood Carving: Doctors Forrest Kracaw, Roy Nelson, F. W. Edmonds, Sydney Smith, Roscoe Van Nuys, L. W. Wuesthoff, and Charles Mell.
Fly Making: Doctors E. N. Ewer, and Frank Bowles.
Oil Painting: Dr. Mark Emerson.
Model Airplanes: Doctor Chesebrough.
Pipes: Dr. James Campbell.
Sea Shells: Dr. Frank Baxter.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. X, No. 5, May, 1912

From Some Editorial Notes:

The Del Monte Meeting.—The annual meeting of the State Society, held at Del Monte on the 16th, 17th, and 18th of last month, was in every way a distinct success. There was such a large amount of business introduced, and some of the reports and resolutions were received so late—most of them not being turned in until the time of the meeting—that it is impossible to include the full and official report of the forty-second annual meeting in this issue of the *Journal*. Some of the business matters brought up will be found to be of great importance to our several county societies; other matters were first referred to committees, and these may perhaps have taken some action by the time the next issue is ready for the press.

Throughout the session there was displayed not only keen interest in all matters pertaining to the affairs of the Society and to the business presented, but also a harmony of feeling and a total lack of bitterness or prejudice that speaks strongly for the continuance of improvement in all parts of the State.

The next meeting will be held at Santa Cruz in April, 1913.

The president is Dr. O. D. Hamlin of Oakland.

The first vice-president is Dr. Saxton Pope of Watsonville.

The second vice-president is Dr. Fred Tebbe of Siskiyou.

The secretary is Dr. Philip Mills Jones of San Francisco. . . .

Doctor Wiley.—Through the lifetime of a generation Dr. Harvey W. Wiley has served as Chief of the Bureau of Chemistry in the Department of Agriculture. His recent resignation has caused the press of the country to unite in a wail of protest at his departure from an office which he filled with such conspicuous success. Doubtless, Doctor Wiley long ago proved himself peculiarly fitted for the difficult position he occupied: his stupendous energy, his untiring patience, his unswerving honesty, combined with his scientific knowledge, make his record one without equal in his department. Doubtless, had it not been for his persistence, the Food and Drugs Act of 1906 would have been as innocuous to the manufacturers of adulterated foodstuffs as previous pure food legislation had been. . . .

Keep It in Your Office.—Ye fortunate mortals who have patients sitting in your reception rooms awaiting their turn, why not put some good reading in said reception room for the improvement of the mind of the waiting person? Why not let him read "Nostrums and Quackery," published by the American Medical Association, price fifty cents, with your name stamped on the outside cover? . . .

Protecting a Gullible Public.—Under this caption the Pasadena *Daily News* has an editorial in its issue for March 22 that is well worth reading. The *News* announces its policy in regard to fake and fraudulent "doctor" advertisements. Here is a newspaper the owner of which does not wish to soil his hands with the dirty money—and such "easy money"—of the quack and the charlatan. . . .

From an Article on "Treatment of Severe Cases of Diabetes" by Emile Schmoll, M. D., San Francisco.—The mystery which has always shrouded the etiology of glyco-

(Continued in Front Advertising Section, Page 15)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.

Secretary-Treasurer

News

"Attorney-General U. S. Webb today advised Dr. C. B. Pinkham, Secretary-Treasurer of the State Board of Medical Examiners, that cosmetologists are prohibited by law from dropping or spraying liquid preparations in the human eye. Doctor Pinkham requested the opinion after an investigation disclosed that a large number of so-called beauty salons, located in department stores, provided various eye lotions which were used by cosmetologists in treating the patrons' eyes. . . ." (Sacramento *Bee*, March 24, 1937.)

"Governor Frank F. Merriam today appointed Dr. Roy F. Terry, Long Beach, as a member of the State Board of Public Health, succeeding Dr. Gifford L. Sobey, Paso Robles, whose term expired." (Los Angeles *Illustrated Daily News*, March 31, 1937.)

Reappointment of Drs. Edward M. Pallette and George H. Kress, both of Los Angeles, as members of the State Board of Public Health, was announced yesterday by Governor Merriam.

Doctor Pallette, President of the California Medical Association and a surgeon here for thirty-five years, was first appointed by the late Governor Rolph. His new term will expire January 15, 1939.

Doctor Kress, a member of the General Hospital staff here and editor of the California Medical Association journal, was also appointed by Rolph. His term will expire January 15, 1941. (Los Angeles *Examiner*, April 6, 1937.)

J. Walter Clark, D. C., recently addressed to this magazine a communication reading as follows:

In the July to December, 1936, Volume 45, No. 6, edition of your magazine, CALIFORNIA AND WESTERN MEDICINE, under the heading, California State Board of Medical Examiners—Index XI, there appears this notation: "Clark, J. Walter, D. C., guilty of burglary. Probation three years (July, 1936), Adv. p. 22." I wish to state that I am J. Walter Clark, D. C., and that the above notation is incorrect. I was charged with the receiving of stolen goods—not burglary.

There is a vast difference between these two charges, the charge of burglary being much more detrimental to my character and constitutes felony.

I believe you have either been misinformed or it may be a misprint, but I feel I have the right to ask you to make a correction of this statement in the next issue of this same journal. I feel this is only fair to me and my future as well as to you and the authenticity of your magazine.

The particular item to which objection is made was that appearing under the heading "California State Board of Medical Examiners—Index." No objection is made to the news story which was carried in the July, 1936, issue of said magazine. Such news item read as follows:

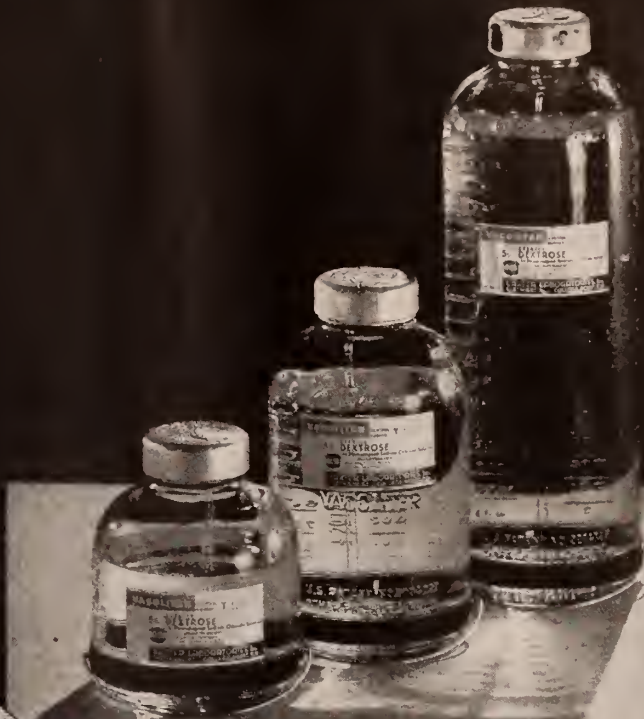
Dr. J. Walter Clark, South Gate and Huntington Park chiropractor, today was free on three years' probation in connection with the burglarizing of the Los Angeles Drug Company of \$30,000 worth of drug accessories in five months.

This item was quoted as being taken from the Huntington Park *Signal*, May 9, 1936.

Since receipt of Doctor Clark's communication we have sought further information as to the offense of which Doctor Clark was found guilty. The Los Angeles Police Department, under date of April 9, 1937, advises that Walter J. Clark, No. 31707-M11, was arrested by that

(Continued in Front Advertising Section, Page 20)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.



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Evidence: Admissibility of Roentgenograms for Purposes of Comparison.—The plaintiff's pelvis was fractured when she was struck by an automobile driven by the defendant. She sued the defendant to recover damages and obtained judgment in the trial court. The defendant thereupon appealed to the District Court of Appeal, Third District, California.

The defendant contended that the trial court erred in admitting in evidence, without proper foundation, a roentgenogram of a normal pelvis apparently for the purpose of comparison with a roentgenogram taken of the plaintiff's pelvis. The contention of the defendant was without merit, in the opinion of the District Court of Appeal. The use of skeletons, charts, and diagrams is common in trials to show the normal structure of the human body, and the court of appeal could not perceive why the use of roentgenograms of a normal bone arrangement may not, likewise, be used for illustration and comparison. The roentgenogram offered in evidence was that of the pelvis of a normal woman about the age, size, and figure of the plaintiff and, in the opinion of the court, was properly admitted for the purpose of enabling the witness to explain to the jury a roentgenogram already in evidence. Finding no error, the judgment of the trial court was affirmed. (*DeMartini vs. McDonnell* (Calif.), 58 P. (2d) 170.)—*Journal A. M. A.*

Persons Engaged in Care of Sick in Germany.—The National Health Bureau has issued an official statistical report on the number of persons actively engaged in the medical, nursing and kindred professions as of January 1, 1935. The report includes statistics on all other groups, the members of which derive their livelihood from the care of the sick. In all, 286,948 persons were included within the survey. That a majority were females is due to the fact that by far the largest unit listed comprises members of the nursing profession. The medical profession, as the keystone of all the professional groups covered by the survey, represented 17 per cent of the

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foregoing grand total; its members numbered 47,419 persons who are licensed to practice medicine in Germany. There were 44,491 men physicians and 2,928 women physicians. These figures represent an increase in the total number of physicians of 0.3 per cent (144) over 1934. There were 12,088 licensed dental physicians, of whom 785 were women; 10,981 registered pharmacists, including 549 women; 25,737 midwives; 20,298 dentists (dental practitioners without university training), including 2,363 women; 11,922 bone setters, masseurs, and so on, including 5,494 women; 126,008 trained nurses, of whom the vast majority (104,822) were women; 6,869 nurses especially trained to care for infants; 1,240 confinement assistants; 5,581 disinfectors, including 593 women, and finally there were 14,023 heilpraktiker (lay practitioners who by no means are to be considered as physicians, but rather as so many quacks), including 3,359 women. Lumping all these groups together as a unit, the distribution, according to sex, was found to have been 130,520 men and 156,428 women. While the foregoing figures may be regarded as official, they still lack uniformity, as this type of statistical survey is relatively new and not all of the German states have instituted compulsory registration for the members of all these groups.

Only a slight increase took place in the number of regular physicians during 1934. There were 7.2 physicians to each 10,000 of population and 10.1 physicians to each 100 square kilometers of area, or one doctor to each 1,388 inhabitants and to each 9.9 square kilometers of area. The previously mentioned 144 physicians were chiefly women, 127 new women physicians to only seventeen men. From this, one may conclude that the proportion of women physicians will undergo a yet greater increase in the near future, since it is significantly higher among the rising generation as compared with the older generation of physicians. In the year 1933-1934, 15.4 per cent of all persons receiving the license to practice medicine were women (324 women in a total of 2,109 persons licensed); of students who passed the preliminary examination in

medicine (given at the end of the first five semesters of study) 22.1 per cent were women; at the same time 19.8 per cent of all medical students were women. The total number of licenses granted underwent a sharp increase in 1933-1934 (2,109 persons licensed as against 1,280 in 1932-1933). On the other hand, there was but a slight increase in the number of students who passed the preliminary examination (4,943 in 1933-1934 against 4,836 in 1932-1933) and, throughout, the increase in the number of women was considerably greater than the increase in the number of men. Conversely, the total number of medical students declined, although the number of women students declined at a slower rate than that of the men students. The statistics on the distribution of medical students over various semesters show that the high figures for those entering the medical profession will remain about the same for some three years and then will suddenly drop to about one-half their former value. How long the number of new admissions will remain at so low a level cannot be computed beforehand, since the exigencies of the work service and military service are factors conducive to a retrogression in the number of students admitted to the medical schools. On the other hand, the decline in the number of women matriculants is so considerable that it cannot alone be attributed to the work service but may be taken to indicate that fewer women contemplate medicine as a career. Whereas the number of matriculants in medicine amounted in 1933-1934 to 2,866 men and 852 women, corresponding figures for 1934-1935 show only 1,826 men and 338 women or, in terms of percentage of the matriculants in the preceding academic year, only 65 per cent and 39.7 per cent for men and women, respectively. The number of specializing physicians January 1, 1935, showed an increase of 1 per cent over January 1, 1934. The greatest increase was among the internists, whereas the greatest decrease was among the dermatologists and venereologists. The proportion of women is by far the highest among pediatricians

(Continued on Next Page)

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(Continued from Preceding Page)

and lowest among surgeons and otorhinolaryngologists. Table 1 shows in detail the distribution of physicians engaged in the specialties.

TABLE 1.—Distribution of Specialists as of Jan. 1, 1935

Specialties	Absolute Number		Number on Jan. 1, 1935 Listed on Jan. 1, 1934	Number Per 100 Physicians	Women Physicians in the Specialties	
	Jan. 1, 1934	Jan. 1, 1935			Absolute Number	Number Per 100 Specialists of Both Sexes in Same Field
Surgery	2,729	2,682	98	5.7	24	0.9
Gynecology and obstetrics	1,757	1,781	101	3.8	99	5.6
Internal medicine	2,795	2,975	106	6.3	89	3.0
Pediatrics	1,128	1,188	105	2.5	328	27.6
Dermatology and venereology	1,813	1,746	96	3.7	68	3.9
Mental and nervous diseases	1,653	1,687	102	3.6	78	4.6
Ophthalmology	1,360	1,344	99	2.8	70	5.2
Otorhinolaryngology	1,476	1,498	101	3.2	15	1.0
Totals	14,711	14,901	101	31.4	771	5.2

It is further estimated that 4 per cent of physicians were in government service and 17 per cent were occupying permanent posts in institutions for the sick. Only one-half of all physicians had selected to exercise their profession in a general, independent, nonspecialized practice. Detailed statistics on the groups lying outside regular medicine are of scant interest with the exception of the figures for the "heilpraktiker." These lay practitioners occupied a more favorable position under the new régime



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than that formerly enjoyed by them, a fact mentioned in previous letters. In this survey all unlicensed persons who were professionally engaged in the treatment of the sick were three such heilpraktikers to each ten regular physicians in Germany; the corresponding ratio was 2.6:10 in 1929, 1.5:10 in 1909, 1.1:10 in 1878, and 0.5:10 in 1876. Sixty years ago there were only 670 heilpraktiker (according to the rather incomplete records of those times); today there are 14,023 such practitioners. The increase in the number of heilpraktiker took place at a greater rate than the increase in the number of regular physicians until 1927 and has made yet further advances since that time. In 1935 a decrease is to be noted for the first time, presumably a consequence of the measures instituted for the "purgation" of the ranks of the lay practitioners. The increase in the number of heilpraktiker prior to 1935 is shown in Table 2.

TABLE 2.—Increase in Number of Heilpraktiker Prior to 1935

Year	Number of Heilpraktiker	Number of Women Heilpraktiker	Heilpraktiker Per 10,000 of Population	Heilpraktiker to Each Ten Physicians
1876	670	95	0.16	0.49
1887	1,713	305	0.36	1.08
1898	3,059	766	0.56	1.24
1909	4,468	1,322	0.70	1.46
1927	11,761	2,832	1.86	2.70
1928	12,098	2,803	1.90	2.63
1929	12,413	3,091	1.94	2.61
1930	12,942	3,094	2.01	2.74
1931	14,031	3,372	2.17	2.93
1934	14,266	3,378	2.19	3.02
1935	14,023	3,359	2.13	2.96

The proportion of women is higher among the heilpraktiker than among the physicians or the dental physicians. Before the war the proportion of women heilpraktiker had increased from 14 per cent to 30 per cent;

after the war it remained with great regularity at around 24 per cent—not quite one-fourth of the total. An explanation of the considerable proportion of women lay practitioners may be found in the fact that traditionally many farmers' wives and nurses of one sort or another, including women in holy orders and masseuses, were classed as heilpraktiker.—*American Medical Association's Berlin Correspondent.*

Paternity: Admissibility of Blood-Grouping Tests to Determine Paternity.—The prosecutrix gave birth to an illegitimate baby and the defendant was named as the father. In a prosecution for rape, the defendant asked the trial court to require the prosecutrix and her baby to furnish a few drops of blood for the purpose of having it tested and compared with the blood of the defendant. By this test, the defendant maintained, it might be possible to demonstrate as a scientific fact the impossibility of his paternity. The trial court refused to order the test, and the defendant was convicted of second degree rape. On appeal, the Supreme Court of South Dakota upheld the refusal of the trial court to order the test, holding:

"That it does not sufficiently appear from the record in this case that modern medical science is agreed upon the transmissibility of blood characteristics to such an extent that it can be accepted as an unquestioned scientific fact that, if the blood groupings of the parents are known, the blood group of the offspring can be necessarily determined, or that, if the blood groupings of the mother and child are known, it can be accepted as a positively established scientific fact that the blood group of the father could not have been a certain specific characteristic group." (*State vs. Damm* (S. D.), 252 N. W. 7.)

A rehearing was granted in the case, limited to the ruling of the trial court with respect to the blood test.

Our former opinion, said the Supreme Court on rehearing, seems to have been widely accepted and understood as a holding that the reliability of the blood test was

(Continued on Next Page)

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(Continued from Preceding Page)

not as yet generally established or recognized by the consensus of expert opinion in the particular field of science wherein the matter lies. There was no intention in that opinion to express a conviction one way or the other on the abstract question of the reliability of the test as a matter of science. Our former opinion, continued the court, went no further than to hold that the record itself failed to establish the reliability of the blood test. In view of this misunderstanding of the purport of its former decision, the Supreme Court considered it advisable, on rehearing, to state that, in its opinion, the reliability of the blood test is definitely established as a matter of expert scientific opinion entertained by authorities in the field, and that the time has undoubtedly arrived when the results of such tests, made by competent persons and properly offered in evidence, should be deemed admissible in a court of justice whenever paternity is in issue. The foregoing statement was made because, in the words of the court: "We do not wish any misapprehension as to the views of this court by any possibility to deter other courts from accepting and acting upon a tenet of biological science which we are convinced is now fully ripe for acceptance in medico-legal cases."

All judicial powers, said the court, are vested in the courts, and the judiciary constitutes a separate, distinct, and coördinate department of the government of the sovereign state. The primary function of the judiciary is the administration of justice, and justice can never be rightly administered unless truth is first ascertained as nearly as may be. The citizen holds his citizenship subject to the duty to furnish to the courts, from time to time and within reasonable limits, such assistance as the courts may demand of him in their efforts to ascertain truth in controversies before them. This is just as much a part of the citizen's inescapable duty of supporting his government as is military service in time of war, or any other like obligation. The court could perceive no valid reason why courts of record may not require of any person within their jurisdiction the furnishing of a few drops

of blood for test purposes when so to do will or may materially assist in administering justice in a pending matter. The order for such test should be adequately safeguarded. The order should not issue as a matter of absolute right but in the sound discretion of the court. A trial judge should not be a mere umpire presiding over a game of skill conducted by counsel, and the court could conceive of no valid reason why a trial judge might not of his own motion in a given case, if he thought it likely to be helpful, order the making of a blood test by a competent person and a report thereon under oath subject to cross-examination by both parties. Recapitulating its views, the Court said:

"We think (1) the reliability of the blood test is universally conceded by competent scientific authorities; (2) a trial court of record in this state has inherent power and authority, in its reviewable discretion, to order the taking of blood for such purposes in cases where paternity is an issue and where, in the opinion of the court, the making and reporting of such test will be, or is likely to be, helpful in ascertaining the truth."

Notwithstanding the foregoing views, the Supreme Court felt impelled to hold that the trial court did not err in refusing to make the order requested. The case, the Supreme Court observed, was tried in October, 1931, and the literature on the topic of the scientific reliability of the blood test appeared for the most part subsequent to that date. We are far from willing, the court said, to say that it was error for a trial judge in South Dakota, at the time of the trial of this case, to fail or refuse to take judicial notice of such reliability. If such reliability was not, at the time of the trial of the case, a matter which the trial court was obligated judicially to notice, then it was necessary for the applicant for the order to prove such reliability by proper and satisfactory expert testimony. This he failed to do. Furthermore, there was no adequate showing that if the requested order was granted the defendant could and would have the tests made by a

(Continued on Page 41)

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(Continued from Page 38)

competent, capable and experienced person. The judgment of the trial court was consequently affirmed. (*State vs. Damm* (S. D.), 266 N. W. 667.—*Journal A. M. A.*)

A Commission to Study Hospital Lotteries.—The Government of South Australia appointed a royal commission to inquire whether it is desirable to institute lotteries in South Australia for the purpose of raising funds to assist in the finance of hospitals and other charitable institutions. The Commission took evidence in the different states of the commonwealth and had special statistical information about lotteries of Great Britain, Ireland, France, the United States and Canada. The Commission expressed itself in its report as being not unduly influenced by the religious or ethical aspect. It says it would not have felt justified in coming to its conclusion or objecting to the lottery system on the ground of ethical objection, if on other grounds it had been found desirable. There is a real difference in principle between a government on the one hand taxing private betting or other private activities of the people and on the other hand introducing a lottery for the purpose of raising money for one of its essential social services. In the former case the Government takes no part in the promotion of the activities on

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which the tax is levied. In the case of a lottery, Parliament either directly or through a department established by it promotes the lottery for the purpose of profit and takes an active part in inducing people to subscribe to it.

(Continued on Next Page)



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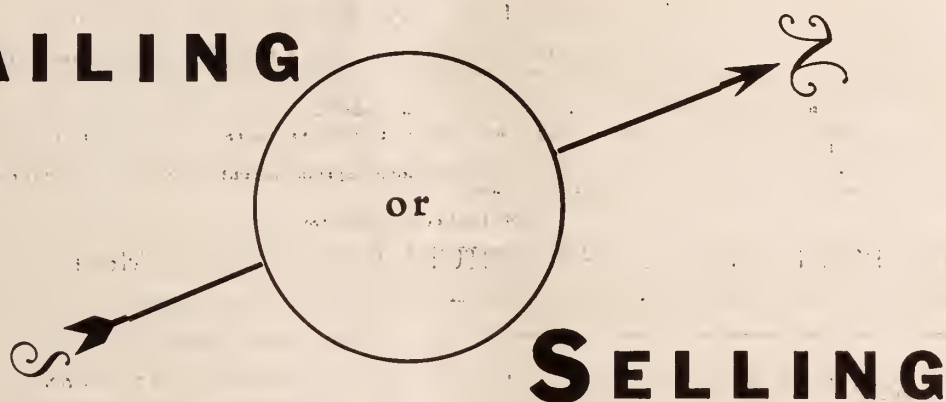
No Australian government urges people by advertisement to bet on horse races in order that more revenue may be obtained from betting or to go to the pictures so that the amusement tax revenue may be increased, but when there are lotteries the public is definitely encouraged to do so.

The Commission was much impressed in the course of its investigations by what appeared to be the political repercussions of lotteries either conducted by governments or under a government license. The Commission gained the definite impression that lotteries conducted on the lines of those of New South Wales, Queensland, and Tasmania tend to become the masters rather than the servants of the government that "controls" them. The Commission considered that the state of affairs tends to demoralize governments. After full and careful investigation the Commission satisfied itself that the lottery does not and cannot solve the hospital finance problem. Even in Ireland the immense Irish sweep has not relieved the Government or the local authorities of their hospital obligations, and in Western Australia and in Queensland lotteries have not helped the Government to any material extent. The existence of lotteries in four of the six Australian states, and the seeming benefits derived from them, give an impression that a lottery is desirable. After thorough investigation, however, the Commission is satisfied that these benefits are more superficial than real.

It may appear difficult to understand why it is that, with all the revenue that lotteries bring in, the Government or local authorities do not secure corresponding relief. There are several contributing factors to this position: (1) The people of Australia are becoming more and more hospital-minded, which means an increasing demand for accommodation. (2) The existence of a lottery tends to create in the people a demand as of right for a much higher standard of hospital buildings and equipment, and for more hospitals. (3) The practice has been generally to use lottery moneys for capital expenditure and, therefore, the cost of maintenance necessarily

(Continued on Page 44)

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increases. (4) The existence of a lottery tends to decrease the voluntary contributions for hospital and charitable purposes, and this factor is greatly accentuated when there is a rate or tax for hospitals as well. (5) Where charities are associated with lotteries, the charitable institutions set up higher standards. (6) It may be that one of the reasons why lottery moneys are spent in the manner in which they are is that such expenditure provides an excellent advertisement for the lottery. For these reasons the Commission found that the establishment of a lottery will not materially relieve the Government or the local governing authorities of their burdens for hospitals or charities. In fact, because of the higher standard that is built up through the expenditure of lottery moneys as capital the ultimate burden is likely to be increased by the existence of a lottery.

Everywhere, says the report, there is a tendency to increase the prizes, and especially the first prize; and everywhere the lottery is an exploitation of the gullibility of the public and the widespread gambling instinct. In fact, so deep-seated has this legalized form of gambling become that it is doubtful whether any government would dare to introduce legislation to abolish these lotteries. The Commission concluded that a lottery, as a form of hospital finance, provides an unstable method that is demoralizing to the Government, distinctly injurious to traders, and detrimental in the end to the poorer sections of the community, who contribute the bulk of the receipts. If the people who buy lottery tickets can easily afford the money, they can afford to pay their share of the direct taxation necessary to support hospitals. If they cannot afford the money, the state should not take their money. From the establishment of the "golden casket" in Queensland nearly twenty years ago the total receipts amounted to £12,000,000, the prize money amounted to £7,000,000, and the sum paid to hospitals and charities after payment of expenses was £3,000,000. These figures confirm the Commission in its belief that the lottery does not and



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cannot solve the hospital finance problem, and consequently it was recommended that the practice should not be permitted in South Australia.—*Australian Correspondent.*

The American Social Hygiene Association.—The objectives and methods the Association is working for include:

The provision of adequate professional health and medical services, supplemented as necessary by federal, state, and community facilities; inclusion of syphilis and gonococcal infections as major problems of such services; development of opportunities for graduate physicians to gain practical experience in diagnosing and treating these diseases; establishment of adequate instruction for students being trained for the professions and technical services concerned; and protection of the public from medical quacks and others seeking to exploit the sick and those believing themselves to be infected.

The securing of community environments favorable to family life and the safeguarding of children and adolescents from conditions leading to sex delinquency; study of laws and their practical application; promotion of protective measures advancing standards of public and private morals; the development of recreation for young and old adapted to their increasing leisure time; and direction of all these activities toward relations of men and women conducive to mutual respect, wholesome companionship, marriage, and parenthood.

The promotion of public information, (1) to insure popular understanding and support of social hygiene as an integral part of permanent community activities; (2) to provide particularly for protection of the individual against the diseases syphilis and gonorrhea.

The establishment of correlated educational, religious, and social instruction and training directed toward (1) the general objective of making the family biologically and sociologically effective in securing for each generation good heredity and wise parental care in successful homes; (2) the acquiring of individual knowledge and control

most likely to insure the functioning of sex as a useful influence in personal and family life.

The Association works through:

The membership of the Association, which collectively represents every part of the United States and the experience and judgment of all professional and lay groups. The members constitute a means of securing dependable views and cross sections of public opinion on social hygiene questions. They also provide an essential medium for exchanging, among local and state groups, data and experience with new methods.

The officers and members of other agencies, which include social hygiene activities in their respective programs. The coöperative projects with such organizations serve to promote teamwork, avoid duplication and unnecessary specialization in health and welfare programs, while decreasing the costs of administration and broadening the base of support.

The public information and education facilities of the schools, the church, the press, the radio, the screen, professional and organized groups, lectures and institutes.

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The Association may be addressed at 50 West Fiftieth Street, New York City.

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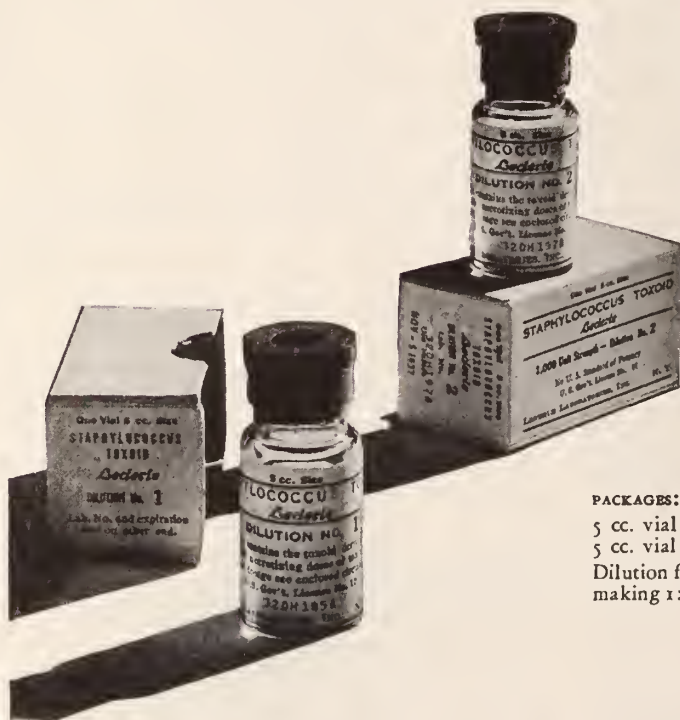
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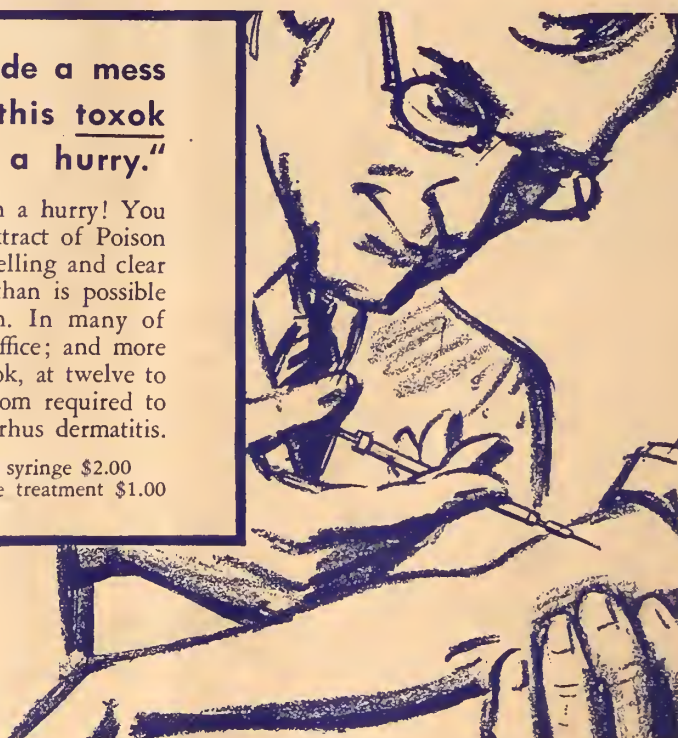
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Karl L. Schaupp.....	San Francisco	1940	E. Vincent Askey.....Chair., Com. on Membership and Organization		
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ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

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2404 Broadway, Oakland
President, H. Gordon MacLean, 230 Grand Avenue, Oakland.
Secretary, Gertrude Moore, 2404 Broadway, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte County Medical Society
President, John H. White, 315 Wall Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Clara H. Spalding, 331 Eighth Street, Richmond.
Secretary, Thomas J. Dozier, 202 G Street, Antioch.
Meeting, *Second Tuesday, 8 p. m.*

Fresno County Medical Society
President, J. M. Frawley, T. W. Patterson Building, Fresno.
Secretary, O. B. Doyle, Bank of America Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Allan R. Watson, 350 E Street, Eureka.
Secretary, Lawrence A. Wing, Fifth and F Streets, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Floyd A. Burger, Box 193, El Centro.
Secretary, Merritt C. Canfield, 204 Professional Building, El Centro.
Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

Kern County Medical Society
President, H. R. McAllister, Professional Building, Taft.
Secretary, C. S. Compton, 428 C Street, Bakersfield.
Meeting, *Third Thursday, 8:30 p. m.*

Kings County Medical Society
President, P. K. Edmunds, Corcoran.
Secretary, William A. Johnstone, Hanford.
Meeting, *Second Monday, 8 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, C. I. Burnett, Susanville.
Secretary, Fred J. Davis, Jr., Westwood.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, John P. Nuttall, 203 Professional Building, Santa Monica.
Secretary, E. Vincent Askey, 1925 Wilshire Boulevard, Los Angeles.
Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Anne L. Brady, Albert Building, San Rafael.
Secretary, Carl W. Clark, 510 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society
President, Thomas P. Hill, Lakeport.
Secretary, Charles A. Craig, Lakeport.
Meeting, *On Call.*

Merced County Medical Society
President, Max Brannon, Merced.
Secretary, Fred O. Lien, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Garth Parker, 8 East Alisal Street, Salinas
Secretary, Arthur L. Wessels, Salinas National Bank Building, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, Fred Heegler, Migliavacca Building, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Society
President, Waldo S. Wehrly, 620 N. Main St., Santa Ana.
Secretary, Glenn Curtis, 323 So. Pomona Street, Brea.
Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital, Orange.*

Placer County Medical Society
President, C. E. Lewis, 59 Lincoln Ave., Auburn.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, H. L. Ratliff, 3616 Main Street, Riverside.
Secretary, Thomas A. Card, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Raymond M. Wallerius, 312 Physicians Building, Sacramento.
Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, L. C. Hull, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, D. C. Mock, 215 Cajon Street, Redlands.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego
President, S. J. McClendon, 2001 Fourth Street, San Diego.
Secretary, W. H. Newman, Medico-Dental Building, San Diego.
Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, T. Henshaw Kelly, 490 Post Street, San Francisco.
Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.
Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, John S. Blinn, 1101 Medico-Dental Building, Stockton.
Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Charles R. Kennedy, Bank of America Building, Paso Robles.
Secretary, E. D. Anderson, 1120 Morro Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Mulholland's Grill, San Luis Obispo.*
(Roster lists continued on advertising page 6)

San Mateo County Medical Society
President, Frank S. Gregory, 736 Main Street, Redwood City.
Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Irving Wills, 1421 State Building, Santa Barbara.
Secretary, William H. Eaton, 822 De la Guerra Terrace, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
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Secretary, Leslie B. Magoon, Medico-Dental Building, San Jose.
Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society
President, A. N. Nittler, 36½ Pacific Avenue, Santa Cruz.
Secretary, Samuel B. Randall, Farmers and Merchants Bank Building, Santa Cruz.
Meeting, *Second Tuesday, 7:30 p. m., Hotel Rio del Mar, Aptos.*

Shasta County Medical Society
President, Oscar J. Hansen, 318 Yuba Street, Redding.
Secretary, Leslie J. Seeley, 1432 York Street, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, E. F. Carlson, Fort Jones.
Secretary, J. B. McGuire, Mt. Shasta City.
Meeting, *Second Sunday.*

Solano County Medical Society
President, H. Brownlie Perkins, 445 Georgia Street, Vallejo.
Secretary, John W. Green, Box 539, Vallejo.
Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, C. B. Andrews, Sonoma.
Secretary, C. M. Carlson, 1055 Fourth Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Marion C. Collins, Turlock.
Secretary, Edwin F. Hagedorn, Box 834, Modesto.
Meeting, *Second Friday.*

Tehama County Medical Society
President, Donald E. Thompson, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, J. C. McClure, Lindsay.
Secretary, Karl F. Weiss, Security First National Bank Building, Visalia.
Meeting, *Sunday Evening once a month.*

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President, F. R. Hendricks, 885 East Main Street, Ventura.
Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society
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Secretary, Ray E. Nichols, Woodland.
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California Northern District Medical Society President—Percy B. Gallegos, 242 North Sutter Street, Stockton. Secretary—Dave F. Dozier, 926 J Street, Sacramento.	Southern California Medical Association President, Franklin R. Nuzum, Cottage Hospital, Santa Barbara. Secretary, Robert W. Langley, 1002 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.	Better Health Foundation President, *Reginald Knight Smith, 490 Post Street, San Francisco. Chairman, Executive Committee, Walter B. Coffey, 65 Market Street, San Francisco. Treasurer, John Gallwey, 1195 Bush Street, San Francisco. Secretary, Celestine J. Sullivan, 490 Post Street, San Francisco. * Deceased.

DIARRRHEA

"the commonest ailment of infants in the summer months"

(HOLT AND McINTOSH: HOLT'S DISEASES OF INFANCY AND CHILDHOOD, 1933)

One of the outstanding features of DEXTRI-MALTOSE is that it is almost unanimously preferred as the carbohydrate in the management of infantile diarrhea.

In diarrhea, "The sugar is added gradually, conditions admit, some sugar other than milk sugar or cane sugar being used, preferably dextrose and maltose."—H. E. Small: *Diarrhoea in bottle-fed infants*, J. Maine M. A. 12:152-158, Jan. 1932.

In diarrhea, "Carbohydrates, in the form of can be handled without trouble."—B. B. Jones: *A discussion of some of the commoner types of infantile diarrhea, and the principles of the diets used in their treatment*, Monthly, 66: 411, 1932.

"The most desirable sugar is dextri-maltose because of all the sugars maltose is least apt to cause."—A. I. Blau: *The use of protein milk*, J. Pediatr. 1: 359, April 2, 1932.

Concerning the treatment of diarrhea, "If the weight remains stationary, it is an indication that loss of substance is occurring through the stools, mostly in the form of alkaline salts. To equalize this loss of substance, the diet must be increased, but in such a way as to avoid causing fermentation. This may be done by adding dextri-maltose and preparations of protein to the food, increasing the calories until the infant is taking 160 calories per kilo. of body weight."—H. L. Rainoff: *Nutritional disturbances*, Arch. Pediatr., 41:771 Nos., 1924.

"... Professor Finkelstein in the science of being able to feed the infant with fermented like protein milk, after only one day on the vantage of being able to safely add a carbohydrate like Dextri-Maltose No. 1 or No. 2 to the protein milk within a few days, enables one to gradually bring the infant up to its basal level a short time. When protein milk was used, the result that many children were advised to be of collapse. The suggestion of Toronto, Canada, that Dextri-Maltose be added to protein milk, was of great periods without adding carbohydrate. It is emphasized that regardless of the stools, carbohydrate must be added to avoid collapse."—G. J. Feldstein: *Diarrhea in infants and children*, Arch. Pediatr., 41: 1933.

In cases of malnutrition and indigestion, "The appetite improves rapidly, and the stools soon become normal in appearance. By this I refer to an intelligent person. I have used it in proper proportions to looseness, for I find there is a tendency to looseness."—M. Ludd: *For the treatment of diarrhea*, J. Pediatr., 1: 196, July, 1932.

"After the preliminary short period of starvation, protein milk should be used. ... When dextri-maltose has been sufficiently checked, dextri-maltose may be added and gradually increased until from 4 to 6 tablespoons are being used."—W. L. Denney: *Acute nutritional disturbances of infancy*, Univ. West. Ontario M. J. 2:132-137, April, 1932.

Regarding the treatment of diarrhea, "In our experience, the most satisfactory carbohydrate for routine use is Mead's dextrin-maltose No. 1."—F. R. Taylor: *"Summer Complaints," Southern Med. & Surg.*, pp. 655-559, August, 1927.

In cases of diarrhea, "For the first day or so no sugar should be added to the milk. If the bowel movements improve carbohydrates may be added. This should be the one that is most easily assimilated, so dextri-maltose is the carbohydrate of choice."—W. H. McCaslan: *Summer diarrheas in infants and young children*, J. M. A. Alabama, 1:278-282, Jan., 1932.

There is any tendency to sugar fermentation use a preparation with a high dextrin and relatively low maltose content, as Mead's dextri-maltose.

"If it is desired to feed an unusually large amount of sugar to a baby, it is well to use a maltose-dextrin preparation, as in this way there is less danger of bringing about sugar fermentation than if lactose were used."—L. W. Hill: *Practical Infant Feeding*, W. B. Saunders Co., Phila., 1922, p. 206.

"The young one-third milk, usually skimmed at first, and a half ounce of Dextri-Maltose as the carbohydrate, most easily digested. ... Preparations containing the more maltose are more rapidly absorbed, but on the other hand, are more popular to produce diarrhea. ... Lactose which was very popular at one time, is never used in our work. The consensus of opinion seems to be that milk sugar is often a source of indigestion in normal infants and the primary cause of fermentative dyspepsias in infants during the first year of life."—J. H. Reading, Jr.: *Artificial feeding of infants during the first year of life*, Arch. Pediatr., 47:344-354, June, 1930.

"Protein milk may be continued for several weeks when a gradual transition to a whole milk or evaporated milk formula, which will supply about one and one-half to two ounces of whole milk or every pound of body weight, is reached. This should finally have the addition of dextri-maltose amounting to five to seven per cent."—R. A. Strong: *Summer diarrheas in infancy and early childhood*, Arch. Pediatr., 47:344-354, June, 1930.

"The treatment of diarrhea, 'Dextri-maltose preparations are preferred, for they do not ferment readily, are rapidly absorbed and leave very little for fermentation.'—V. A. Blenkle: *Protein milks in infant feeding*, Arch. Pediatr., 42:743-760, Nov., 1925.

"... I begin to add carbohydrates slowly, by replacing 1/4 ounce Casec every two days with 1/4 ounce of Dextri-Maltose, preferably Dextri-Maltose Number one. As a rule, this is tolerated. When one ounce of Dextri-Maltose is used, the Casec, of course, should be discontinued."—I. W. Reed: *The etiology and treatment of diarrhea*, J. Pediatr., 1: 196, July, 1932.

"When sugar causes diarrhoea one can change the form of it. Mead's Dextri-maltose, in small doses is more quickly absorbed and so superior to castor [cane] sugar. Lactose is expensive and seems not to be better than castor sugar."—H. B. Glendon: *Infant Feeding*, J. Pediatr., 1: 196, July, 1932.

"Milk-sugar, which has been so extensively used in the past, should never be used where there is any digestive disturbance. It is not as easily digested as either cane-sugar (granulated sugar) or dextri-maltose. The latter is the best of all sugars to use, especially if there is any tendency to looseness of the bowels."—A. Brown: *The Nutrition of the Infant*, F. D. Goodchild: *Infant Child; Its Care and Feeding*, F. D. Goodchild Company, Toronto, 1933, p. 120.

For cases of fermentative diarrhea, "... the ideal plan of treatment would be to give a food of organisms thrive on) and high in protein. Calcium caseinate milk accomplishes this purpose. In our series of cases, we found it was necessary to use the casein calcium for from 5-8 days; we then stopped it and added dextri-maltose to the formula."—A. G. DeSanctis and L. V. Pader: *The value of calcium caseinate milk in fermentative diarrhea*, Arch. Pediatr., 47:344-354, June, 1930.

Just as DEXTRI-MALTOSE is a carbohydrate modifier of choice, so is CASEC (calcium caseinate) an accepted protein modifier. Casec is of special value for (1) colic and loose green stools in breast-fed infants, (2) fermentative diarrhea in bottle-fed infants, (3) prematures, (4) marasmus, (5) celiac disease. MEAD JOHNSON & CO., EVANSVILLE, IND., U. S. A.

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Mead Johnson & Company, Evansville, Indiana, invite you to send for samples of Mead's Oleum Percomorphum for clinical use during the summer months to replace cod-liver oil.

If one continues to ply one's mind, growth ensues, even in the years formerly supposed to be marked by stagnation and decay. To foster this growth one must not trust too much to the casual gains of everyday work and experience. One must put forth directed efforts. Merely to maintain one's status is not enough. He who is satisfied to stand still will soon slip backward. To grow one must go on learning. So it has come about that education, formerly thought to be an activity limited to the days of one's youth, is now seen in one form or another to be desirable in all periods of life. Thus, one continues to improve; thus, one keeps young.

Do not spend your days waiting for an angel to deliver realized hopes at your door. Go out and toil for them. There are few forms of hard work more wearying than waiting.

Action Pictures.—E. I. du Pont de Nemours & Company, Wilmington, Delaware, announce they have recently taken a great number of action pictures at various du Pont plants, showing important phases in the manufacture of a number of this company's products. These pictures are now available to you for publication. Below we are submitting a list of the pictures on hand from which you are privileged to make a selection of those subjects in which your readers are interested. The list follows: Plastics, Perfumes, Vitamin D Synthesis, Du Pont Film, Alumina Sulphate, Sulphuric Acid, Handling Raw Bauxite, Neoprene, Synthetic Camphor, Dyes, Gardinol, Technical Laboratory, Jackson Laboratory (Including the Semi-Works), Pest-Control Laboratory.

If those who are interested in pictures on any of the above subjects and will communicate with this office, the Company will be very glad to forward a representative group on the subject, or subjects.

The Use of "Benzedrine Inhaler" in Children.—Scarano and Coppolino (Arch. Pediat., 54:97, Feb., 1937) report on the use of "Benzedrine" (benzyl methyl carbamine, S. K. F.) in vapor phase in one hundred cases of nasal congestion in children. The ages of the group ranged between two months and twelve years, with eleven under one year of age.

In 97 per cent, or all but three cases, "Benzedrine" vapor diminished engorgement, established ventilation and relieved congestion promptly and effectively. With nursing infants this form of therapy was particularly effective.

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The authors conclude that "Benzedrine Inhaler" therapy is effective and acceptable to the child patient. At the same time it tends to eliminate the pain and discomfort which so often complicate the administration of liquid vasoconstrictors.

HOSPITALS AND SANATORIUMS

The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

ALUM ROCK SANATORIUM For Treatment of Tuberculosis San Jose, California	FRENCH HOSPITAL General Hospital Geary at Fifth Avenue, San Francisco	PARK SANITARIUM Mental and Nervous, Alcoholic and Drug Addictions 1500 Page Street, San Francisco, California
CALIFORNIA SANITARIUM For Treatment of Tuberculosis Belmont, California	GREENS' EYE HOSPITAL Consultation, Diagnosis and Treatment of Diseases of the Eye Bush and Octavia Streets, San Francisco	SAINT FRANCIS HOSPITAL Limited General Hospital Bush and Hyde Streets, San Francisco
CANYON SANATORIUM For Treatment of Tuberculosis Redwood City, California	LAS ENCINAS SANITARIUM Nervous and General Diseases Las Encinas, Pasadena, California	ST. LUKE'S HOSPITAL Limited General Hospital 27th and Valencia Streets, San Francisco
COLFAX SCHOOL FOR THE TUBERCULOSIS For the Treatment of Tuberculosis Colfax, California	LIVERMORE SANITARIUM Nervous and General Diseases Livermore, California	ST. MARY'S HOSPITAL General Hospital 2200 Hayes Street, San Francisco
COMPTON SANATORIUM AND LAS CAMPANAS HOSPITAL Neuropsychiatric and General Compton, California	OAKS SANITARIUM For Treatment of Tuberculosis Los Gatos, California	TWIN PINES Convalescent and Neuropsychiatric Belmont, California
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National Health Inventory.—The National Health Inventory of the United States Public Health Service, started October 1, 1935, reports in the *Health Officer* for January, 1937 (p. 333), that on October 1, 1936, the work of coding and card-punching data is from 40 to 50 per cent complete. This is much the largest study ever undertaken, covering almost a hundred times as many as the next largest previous study; 867,000 family schedules, representing some 3,000,000 persons, have been returned. Physicians have been asked to confirm diagnoses, and about 555,000 medical report forms were sent to approximately 35,000 doctors and institutions. The responses, with reports, range from 50 to 100 per cent. The study of occupational morbidity and mortality covered industrial sick benefit associations in more than 390 firms and produced 564,000 schedules suitable for analysis. Approximately 40 per cent of the health survey schedules showed no cases of illness. The first tabulations are intended to give (1) the prevalence of each chronic disease, each group, sex and color, (2) the number of persons disabled on the day of enumeration and (3) for a year's period the incidence of illness lasting seven days or longer, together with the number of bed and hospital cases among these illnesses.—*Journal A. M. A.*

Depressions would not come like locusts to vex us if the persons elected to public office were adequately trained in the science and art of government. Jefferson and Hamilton knew the principles underlying their age of agriculture, craft, and small trade. Our complex times can be coped with only by those who command such subjects as economics, law, social and political theory, biology, and logic. A career of the highest merit is now opening to those who have resolved to prepare themselves for governmental service, doing it with such thoroughness as is found among those entering the medical profession. What the country needs above all is voters and office-holders who reason from ascertained premises rather than let themselves be carried to conclusions by fear, favor, or pressure.—Leon J. Richardson.

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First United States Pharmacopeia Supplement Delayed.—There has been a slight delay in the issuance of the United States Pharmacopeia Supplement, due to changes in plans for the binding. It was originally proposed that the "First Supplement" would be issued with a stout paper cover and that this would be enclosed in a strong spring-back binder capable of also holding such future supplements as would be issued.

Now, however, to make the "Supplement" less costly it has been decided to offer it without the spring binder, although the binder will still be available for those who desire it. The purpose of the spring binder has been to keep all "Supplements" together and in such form that they may stand on the shelf by the original Pharmacopeia, or be serviceable in the laboratory. With this change in plans the individual Supplement will be bound in a more substantial, but flexible, cover. The proper development of this feature has taken a longer time than was expected.

The Supplement soon to be issued will be known as the "First Supplement to the Pharmacopeia of the United States, Eleventh Decennial Revision." It may not be necessary to issue Supplements annually, but these will be published whenever the number of new interim revision changes justify their publication. The delay in the release of the "First Supplement" will no doubt necessitate an advance in the date when the new standards are to become official.

Orders for the "First U. S. P. XI Supplement" should be sent to The Mack Printing Company, Easton, Pennsylvania, or to any of the regular distributing agencies for the Pharmacopeia. The price will be \$1.

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Rates for these insertions are \$4 for fifty words or less; additional words 5 cents each.

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There is a principle which is a bar against all information, which is proof against all argument and which cannot fail to keep a man in everlasting ignorance. That principle is "condemnation before investigation."—Herbert Spencer.

Few of the talents that heaven sows are ever brought to light.—Leon J. Richardson.

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MEDICAL DIRECTORS, PASADENA, CALIFORNIA

BOOK REVIEWS

Books received for review are placed in the Library of the California Medical Association, in its central office at San Francisco. Book reviews are written by the Association Secretary.

BOOKS RECEIVED

Handbook of Microscopical Technique. For Workers in Animal and Plant Tissues. Edited by C. E. McClung, Ph.D., Professor of Zoölogy and Director, Zoölogical Laboratory, University of Pennsylvania. Cloth. Pp. 698, with eighty-two illustrations. Second Edition, Revised and Enlarged. Price, \$8. New York: Paul B. Hoeber, Inc., 1937.

Diagnosis and Non-Operative Treatment of the Diseases of the Colon and Rectum. By Gottwald Schwarz, M.D., Professor University of Vienna, Head of X-Ray Department, Kaiserin Elizabeth Hospital, Vienna, and Honorary Member of the American Röntgen Ray Society; Jacques Goldberger, M.D., Consulting Physician, Carlsbad, and Charles Crocker, M.D., New York, N. Y. Cloth. Pp. 540, with 246 illustrations and nine colored plates. Price, \$10.50. New York: Paul B. Hoeber, Inc., 1937.

Surgical Treatment. A Practical Treatise on the Therapy of Surgical Diseases. By James Peter Warbasse, M.D., F. A. C. S., Special Lecturer in the Long Island Medical College, Formerly Attending Surgeon to the Methodist Episcopal and the Wyckoff Heights Hospitals, Brooklyn, New York; and Calvin Mason Smyth, Jr., B. S., M. D., F. A. C. S., Assistant Professor of Surgery in the University of Pennsylvania, Graduate School of Medicine, Surgeon-in-Chief to the Methodist Episcopal Hospital, Philadelphia, and Visiting Surgeon to the Abington Memorial Hospital, Abington, Pennsylvania. Second Edition, Thoroughly Revised and Reset. Three Volumes with Separate Index. Cloth. Pp. 2617, with 2486 illustrations on 2237 figures, some in colors. Price, \$35 a set. Philadelphia: W. B. Saunders Company, 1937.

Dr. Betterman's Diary for the Years 1868, 1873, 1893, 1909, and 1910. Collated from the Old Doctor's Journals and edited by Charles Elton Blanchard, M. D., Editor, The Bulletin of Office Practice. Cloth. Pp. 278. Youngstown, Ohio: Medical Success Press, 1937.

Contributions to the Microscopic Anatomy of the Pancreas. By Paul Langerhans, Berlin, 1869. Reprint of the German Original with an English Translation and an Introductory Essay. By H. Morrison, M. D. Paper. Pp. 39. Price, \$1. Baltimore: The Johns Hopkins Press, 1937.

The Cardiac Glycosides. A series of three lectures delivered in the College of the Pharmaceutical Society of Great Britain under the auspices of the University of London. By Professor Arthur Stoll, D. Sc., M. D. (honoris causa). Cloth. Pp. 80. London: The Pharmaceutical Press, 1937.

(Continued on Next Page)

NEW MEDICAL BOOKS

Bromberg: The Mind of Man.....	\$3.50
Harris: High Blood Pressure.....	3.75
Loewenberg: Clinical Endocrinology.....	8.00
Saxla: Pediatric Dietetics.....	7.00
Schwarz: Diagnosis and Non-operative Treatment of the Diseases of the Colon and Rectum	10.50

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BOOKS RECEIVED

(Continued from Preceding Page)

United States Naval Medical Bulletin. Published Quarterly for the Information of the Medical Department of the Navy. Issued by the Bureau of Medicine and Surgery Navy Department. Division of Publications, Commander Louis H. Roddis, Medical Corps, United States Navy, in Charge. Volume 35, No 2, April, 1937. Paper. Pp. 134. Price, 25 cents. Washington: United States Government Printing Office, 1937.

Transactions of the Western Branch Society of the American Urological Association. Volume 5, 1936. Paper. Pp. 322.

Pression Solaire. Faisceau Energetique et Biologie. Biogenese et Pathogenese. Par le Docteur G. Froin, Ancien Interne des Hôpitaux de Paris. Das Wahre ist das Ganze Hegel. Paper. Pp. 322. Imprimerie De "L'Eclaireur de Nice," 21, Rue Meyerbeer, 21, 1937.

BOOK REVIEWS

Surgical Treatment. By James Peter Warbasse, M. D., F. A. C. S., Special Lecturer in the Long Island Medical College, Formerly Attending Surgeon to the Methodist Episcopal and the Wyckoff Heights Hospitals, Brooklyn, New York; and Calvin Mason Smyth, Jr., B. S., M. D., F. A. C. S., Assistant Professor of Surgery in the University of Pennsylvania, Graduate School of Medicine, Surgeon-in-Chief to the Methodist Episcopal Hospital, Philadelphia, Pennsylvania, and Visiting Surgeon to the Abington Memorial Hospital, Abington, Pennsylvania. Second Edition. Philadelphia and London: W. B. Saunders Company, 1937.

A sound conservative surgical textbook in three volumes which has been revised and brought up to date. While the work is primarily devoted to surgical procedures, it does not neglect the underlying physiologic principles and discusses therapy by drugs, biologics, and radiation. The equipment and preparations for operative treatment are presented in minute detail.

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The work is arranged according to regions, and the anatomy of the regions is described concisely. The descriptions are well illustrated by drawings and diagrams. The technique of surgical procedures is given in detail and well illustrated. In many instances a number of alternative technical methods with the uses and advantages of each are discussed.

The portion dealing with the blood vessels includes a short section on the alternating positive and negative pressure treatment of pregangrenous vascular occlusion. That devoted to the abdomen is complete and very well illustrated.

On the whole it is a splendid text and should be of value especially to the general practitioner.

A Medical Formulary. By E. Quin Thornton, M. D., Emeritus Professor of Therapeutics, Jefferson Medical College. Fourteenth Edition. Pp. 363. Price, \$2.75. Philadelphia: Lea & Febiger.

The first edition of this formulary was printed thirty-eight years ago. The fourteenth edition, revised to date, is now offered. The purpose of this guide is intended to discourage the prescribing of secret and patented preparations that manufacturers foist upon the profession. Physicians are tendered prescription forms that are pharmaceutically and therapeutically potent. They are arranged to meet symptoms and diseases. Their exhibition is clearly indicated.

Physicians will do well to consult this formulary, for it will be most helpful in developing scientific prescribing of drugs.

Medical Urology. By Irvin S. Knoll, B. S., M. D. Pp. 431, illustrated. Price, \$5. St. Louis: C. V. Mosby Company.

This text presents nothing new in urology. It does present to the general practitioner present-day urology principles in a practical understandable manner. It clarifies many details related to diagnosis, pathology and treatment, thus enabling the medical man to better treat the urologic conditions of his patients.

This text, therefore, will be most helpful to the practitioner, for it gives him principles and procedures that



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have been found to be best in eradicating existing pathology and alleviating symptoms.

Contributions to Microscopic Anatomy of the Pancreas.
By Paul Langerhans (1869). Reprint on Translation by H. Morrison, M. D. Johns Hopkins Press. Pp. 39. Price, \$1.

As stated in the title, this book presents the German text and the English translation.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 448)

California Treasury and to be used by the California State Board of Medical Examiners in enforcing the Medical Practice Act of California; and . . .

* * *

Second Session, April 17, 1912, at 8:40 p. m.—The House of Delegates was called to order by the President at 8:40 p. m. and fifty-four delegates responded to the first roll-call; others came in and were seated subsequently. The President declared a quorum present and the House ready for business.

President.—O. D. Hamlin of Oakland, was nominated by G. P. Reynolds and seconded by Dudley Tait. There being no further nominations, the nominations were declared closed and on motion the Secretary was instructed to cast the ballot of the House. This was done and O. D. Hamlin declared elected president for the ensuing year.

First Vice-President.—Saxton Pope of Watsonville was nominated by G. G. Reinle, and there being no other nominations, on motion the Secretary was instructed to cast the ballot of the House, which was done, and Saxton Pope declared elected.

Secretary.—Philip Mills Jones was nominated by George H. Kress, and there being no other nominations, the Presi-

dent was on motion instructed to cast the ballot of the House, which was done.

* * *

Report of the Reference Committee on Reports and New Business.—This report was first read as a whole and was then taken up section by section. . . .

* * *

9. Eye, Ear, Nose and Throat and Urological Sections. The Committee recommends that such official recognition be granted the Eye, Ear, Nose and Throat Section and that any necessary details in connection therewith be referred to the Council. V. G. Vecki moved to amend by including the Urological Section. Amendment accepted.

Address of the President: The Medical Education Problem, by Thomas W. Huntington, M. D., San Francisco.—It is hardly to be expected that anything original can be advanced bearing upon the general subject of medical education. The work of the Council of Medical Education of the American Medical Association, seconded by the efforts of President Pritchett, Abraham Flexner, Arthur Dean Bevan, and many others, has exhausted the subject from the standpoint of modern ideals. General policies have been finally determined and it remains only to call attention to some of the perplexing details which confront all teachers associated with university medical departments. . . .

Report of the Secretary and Editor.—To the House of Delegates of the Medical Society of the State of California. Gentlemen:

. . . Membership. During the year 1911 twenty-four members died and twenty resigned; the resignations were in nearly every case caused by removal from the State.

(Continued on Page 17)

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TWENTY-FIVE YEARS AGO

(Continued from Page 15)

One member was suspended. The total membership on December 31, 1910, was 2,087; on December 31, 1911, it was 2,118, or an increase of thirty-one, in spite of the loss of forty-four by death and resignation. . . .

The medical defense work of the Society is of great importance, and it is absolutely essential that county societies keep their records and collect their dues in a proper business-like manner. . . .

In regard to our publications, the report of the Council will deal in detail; the editor can only say that the year was passed with rather less than the usual number of complications in spite of the increased size of the *Journal*. To the Publication Committee, to the Advertising Committee and to all those who have given assistance, he wishes to extend his thanks.

Respectfully submitted,
Philip Mills Jones,
Secretary.

Report of the Council.
To the House of Delegates.

. . . Medical Defense. Our medical defense plan has been found to work out most admirably. A very large number of threatened suits have never been brought, probably due to the fact that such threats were promptly turned over to our attorneys, who notified the complaining parties that any suit brought would be fully defended. . . .

Appeal to the Council. Dr. — of Santa Barbara appealed to the Council against the action of the Santa Barbara County Medical Society in suspending him from membership for the period of five years. . . .

Report of the Committee on Cancer.—Your Committee on Cancer was empowered by you to prepare a brochure of about one thousand words dealing with the cancer question in a general way, subject to the approval of the Publication Committee, and, if so approved, one hundred thousand copies were to be printed for public distribution through the members of this society. . . .

Consultation among the members of the Cancer Committee, as well as with the members of the Publication Committee and other of our members, brings the committee before you with the opinion that the time is not quite ripe for presenting the cancer problem to the general public in the form of a published statement. We advise, therefore, that the Cancer Committee be, for the present, discharged.

Emmett Rixford
D'Arcy Power
W. Francis B. Wakefield

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From an Article on "Hypophysis Diseases and Their Diagnosis" by C. M. Cooper, M.B., San Francisco.—Vesalius appears to have been the first to describe this organ, and in his "De Corporis Humani Fabrica," 1553, he calls it the "*glans pituitam encipiens*," under the mistaken idea that this organ secreted the "pituita" or nasal mucus. It is of interest to note here that in the lampreys the pituitary tube which remains during life opens on the dorsal aspect of the head, and, though it does not secrete the nasal mucus, it functions as an external nostril. . . .

Report of Medical Education by W. F. Snow, M.D., Sacramento.—To the President, Thomas W. Huntington.

Dear Sir—As representative from California, I attended the series of conferences held in Chicago February 26 to March 1, 1912, inclusive. These conferences were as follows:

1. Conference of American Medical Association on Medical Education.

(Continued on Next Page)

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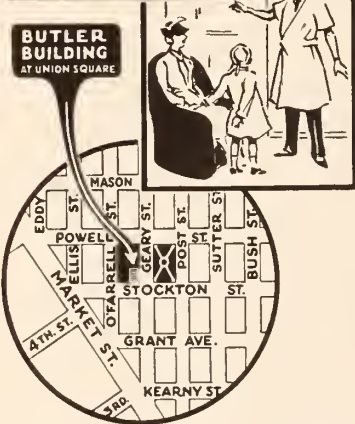
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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

2. Conference of American Medical Association on Medical Legislation.
3. Conference of American Medical Association on Public Health.
4. Conference of State Medical Examining and Licensing Boards.
5. Annual meeting of Association of American Medical Colleges.

All of these meetings were well planned, full of interest, and well attended.

Medical Education.—The most interesting discussions during the sessions on medical education centered about the subjects of practical examinations for the licensing of medical graduates; and the relation of the medical school to a fifth or hospital year. . . .

Minutes of the Annual Meeting of the California Association for the Study and Prevention of Tuberculosis, April, 1912.—The annual meeting of the California Association for the Study and Prevention of Tuberculosis was held Wednesday, April 17, at the Hotel Del Monte, Del Monte, California.

The meeting was called to order by the president, Dr. George H. Kress of Los Angeles, and the annual report of the Secretary and Treasurer for 1911-1912 was read.

It was moved, seconded, and carried, that the report be accepted and ordered placed on file.

It was moved by Dr. W. Jarvis Barlow, and seconded by Dr. George H. Evans of San Francisco, that the report of the Secretary be published in the *State Journal*, and also that it be given publicity in the lay press. Motion carried. . . .

From an Article on "A Proposed Code of Public Health Regulations for California" by John N. Force, M.D., Berkeley.—In the year 1824 one Stephen Dodd, being pastor of the Congregational Church in East Haven, Connecticut, published a thin little volume wherein was set down the history and vital statistics of his town, between its settlement in 1664 and the year 1800. Those who are inclined to charge our modern congested cities with every crime against public health may read with profit the story of East Haven. . . .

From an Article on "Regulation of Hospitals" by William R. Dorr, M.D., San Francisco.—Just at present two separate and distinct movements are on foot in the hospital field which have been brought forward with the intention of regulating hospitals, and thus putting them in a better condition to serve the public at large.

One of these movements, which took the form of a bill presented at the last legislature, has had a temporary setback inasmuch as, although it passed both branches of said legislature, it failed to be signed by the Governor. This proposed law made it the duty of the State Board of Health to license all hospitals that, after a thorough investigation, were found to be thoroughly sanitary in location and equipment and to revoke said license if all the provisions of the law were not observed. Certainly nothing less than this could be required of hospital authorities. There were, however, other provisions of the bill that might be considered as objectionable and which were probably the reason that it failed to be signed.

The other of these movements is the attempt of this society to classify the different hospitals of this city and to point out to its members the hospitals that come up to certain standards and recommend that those, and only those, be patronized by the members of the Society. . . .

Intelligence is the most potent factor that can be directed against disease.

VITAMIN REQUIREMENTS OF MAN

IV. VITAMIN B₁

• The multiple nature of vitamin B has been definitely established by intensive research within the past decade. Considerable quantitative information is now available concerning the requirements of certain species of animals for the various factors contained in the vitamin B complex. At the present time, however, the anti-neuritic vitamin B₁ is the only one of these factors for which the minimum requirement for man can be postulated.

Beriberi-preventing diets of Chinese coolies and natives of Java have been estimated to contain 200 International units of vitamin B₁ (1). Practical use is made of knowledge such as this in the Philippines, where the Bureau of Science, in a successful effort to combat beriberi, dispenses tikitiki (vitamin B₁ concentrate from rice polishings) containing approximately 200 International units of vitamin B₁ per daily dose.

It is generally agreed that the absolute requirement for this factor may be variable, depending upon such factors as size and caloric intake of the individual. However, equations have been derived which take into consideration some of these variables and are useful in estimating the adult vitamin B₁ requirement (2).

Application of these equations indicate that approximately 225 International units of vitamin B₁ per day are required for the average American adult. The average daily infant requirement has been estimated to be

50 International units, increasing to 200 units at the time of adolescence (1). The League of Nations Technical Commission recommends a daily intake of over 150 International units for pregnant and lactating women (3).

While it may be possible to estimate the daily intake of vitamin B₁ which will prevent clinical beriberi, it is not yet possible to state the minimum amount of the vitamin which, when imposed on an otherwise adequate diet, will promote optimum nutrition. There is increasing belief that some of the vague disorders, noted clinically, may be in reality manifestations of suboptimal vitamin B₁ intake (4).

Today, we have the new concept of nutrition which recommends the intelligent inclusion in the varied dietary regime of foods with known nutritive values—thereby insuring that the individual is not dwelling in “the twilight zone of nutrition”. Thus has arisen the concept of “protective foods”.

Results of formal bio-assay have established many commercially canned foods as valuable sources of vitamin B₁ (5).

Incorporation in the diet of the wide variety of foods—made available throughout the year by commercial canning—will assist in the acquisition of an adequate supply of vitamin B₁, as well as other members of the B complex, essential to human nutrition and usually occurring in nature along with the antineuritic factor (6).

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(1) 1934-35. Am. Pub. Health Assn. Year Book. Page 70

(2) The Vitamin B Requirements of Man. G. R. Cowgill Yale University Press. New Haven. 1935

(3) 1936. Nutr. Abst. and Rev. 5, 855

(4) a. 1936. J. Am. Med. Assn. 106, 261
b. 1935. Ibid. 105, 1580

(5) a. 1932. Ind. Eng. Chem. 24, 457
b. 1932. J. Nutrition 5, 307

c. 1934. Ibid. 8, 449
d. 1935. Ibid. 11, 383

(6) 1934. U.S. Pub. Health Rpts. 49, 754

This is the twenty-fifth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 448)

"Charged with practice of 'fake healing' and illegally prescribing medicine, Maria P. Acosta, twenty-four, and Jesus Espinosa, twenty-one, both of 2501 M Street, today were in custody of Bakersfield police. The pair were arrested following investigation by Inspector Bob Knight and Lieutenant George Kerr. Miss Acosta and Espinosa, according to police, informed a Bakersfield woman she was ill because evil spirits had cast a spell over her and that for \$10 they could break the spell. After the initial fee had been paid, it developed that the spell was more complicated than first suspected and an additional \$20 was needed to purchase a 'super-spell buster.' At this stage of the 'cure,' police stepped in to cast a spell of their own over the asserted fake healers." (Bakersfield Californian, April 19, 1937.)

"Definitely abandoning any theory that an illegal operation caused the death of Mrs. Mary Shell, authorities proceeded today with plans to prosecute Mrs. Yanka Zlataroff, her mother, at a hearing next Tuesday before Judge W. H. Dinning in South San Francisco, on charges of performing two other illegal operations. The belief that an illegal operation performed by the mother, a confessed abortionist, might have caused her daughter's death, was given up after Chief of Police Louis Belloni of South San Francisco, who had returned from an investigation trip to Salinas. . . . 'We have no evidence of any abortion having been performed on Mrs. Shell,' he said, 'and if there was, it was performed in Salinas and would not be within our jurisdiction.' Meanwhile Mrs. Zlataroff, who has admitted performing two abortions, returned to her work at a South San Francisco Foundry, apparently unconcerned by the abortion hearing she faces and the fact that she is only at liberty under \$5,000 bond." (Redwood City Tribune, April 15, 1937.)

"Names, addresses and records of more than twenty known or suspected abortionists operating in San Francisco were submitted to Chief Quinn by his Homicide Squad yesterday as the latest sensational offshoot of the graft investigation. The Chief at once notified the commanders of the police districts in which the places are located, with orders for immediate investigation of everyone. . . . In the drive against the sordid and frequently fatal abortion racket, Dr. Charles B. Pinkham, Secretary of the State Board of Medical Examiners, is cooperating with the police. Abortion cases are under jurisdiction of the Homicide Squad, which enters the drive with Captain Arthur Layne in command. . . . The list of known or suspected abortionists was prepared yesterday at Captain of Detectives Charles Dullea's order. As the drive was launched, Doctor Pinkham called on Atherton with a request for whatever evidence the Investigator may have on the abortion racket. Homicide Inspector George Engler, who prepared yesterday's list, cited a number of cases, pending or past, as evidence of the scope of the abortion racket in the city. One of these will come up in Superior Court May 12, to be set for trial. It involves Minerva Geddes, Frances Zoffel, Rudolph Zoffel, and Eland Swindell (a woman) on charges of conspiracy to commit an abortion. . . . The tragic prelude to the case, according to Engler, was the death of Florence Alves, 119 Buckeye Street, Redwood City, following an illegal operation. Engler said that when the abortion death was called to the Homicide Squad's attention, police sent in their own woman investigator. She assertedly called at 1115-1117 McAllister Street, a known abortion 'agency' and made arrangements for an operation through the Swindell woman, who sent the investigator to 431 Ashbury Street. A woman investigator was about to submit to an operation when inspectors broke in by prearrangement. Engler said they made the arrests there and seized crude, unsterilized equipment and instruments. The place, he declared, was supposedly a private residence with a wooden library table serving for

(Continued on Page 22)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 20)

an operating table. Another recent case involving the McAllister Street address, he continued, was that of Mrs. Martha Kauffman, who died there in 1929. Conflicting medical testimony during a protracted coroner's inquiry, which was reopened last October, failed to prove use of instruments and no charges were brought. In still another case, Ora Davis last Friday, was permitted to change a plea of not guilty of murder to guilty of manslaughter and received three years' probation in Superior Court. The charge involved the death of a woman operated on in her own home on February 18. She died from 'horrible lacerations' en route to a hospital." (San Francisco Examiner, April 11, 1937.)

"Police today searched for Dr. William C. Norman, 55-year-old Glendale, physician, who disappeared late yesterday and is believed to be suffering from a recurrence of amnesia. Doctor Norman is described as weighing 195 pounds, blue-eyed, light-brown hair, and almost bald." (Los Angeles Evening News, April 7, 1937). The records of the Board of Medical Examiners do not show any licensee of this name.

"Charged with illegally prescribing morphin sulphate, Dr. Charles F. Vogel, thirty-two, osteopathic physician, was arrested yesterday at 4905½ Second Avenue. Doctor Vogel had been indicted on charges of violation of the Federal Narcotic Act. He was held under \$2,500 bond." (Los Angeles Illustrated Daily News, April 9, 1937.)

"Levon G. Kassabian, thirty-seven, of 817 West Fifty-eighth Street, today was sentenced to pay a fine of \$150 as a provision of two years' probation, given him by Municipal



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Judge James H. Pope on a charge of practicing medicine without a license. Testimony at the trial indicated that Kassabian distributed cards identifying him as a physician, advertised as a doctor and signed prescriptions. . . ." (Los Angeles Evening News, May 5, 1937.)

Investigation reports relate that a warrant was recently issued in the Justice Court of Belvedere Township, Los Angeles, charging Rafael del Castillo Chausal with violation of the Medical Practice Act and bail was set at \$1,500. He was not apprehended. It is said he was convicted last year in Albuquerque, New Mexico, of violation of the Medical Practice Act and assertedly served three months in jail.

Food and Drug Shippers Fined.—Reports of the termination in the Federal Courts of twenty-seven criminal prosecutions were received during March, the Federal Food and Drug Administration reports. Ten of the cases had been brought against shippers of drug products found to vary from the official standards or their own label representations of strength, and patent medicines labeled with extravagant medicinal claims. In the former class were the Standard Chemical Company, Des Moines, Iowa, fined \$10 and costs; George H. Nowland Company, Cincinnati, Ohio, \$40; Endo Products, Inc., New York, N. Y., \$100; S. F. Durst & Company, Philadelphia, Pennsylvania, \$100; Drug Products Company, Inc., Long Island City, New York, \$300; and Sharp & Dohme, Inc., Philadelphia, Pennsylvania, sentence suspended by the court on plea of *nolo contendere*.

Patent medicine manufacturers involved in recent actions, and the offenses for which they were prosecuted, are: Mexican Medicine Company, Inc., Los Angeles, California, "Tabletas Marca Vida," containing compounds of bismuth, calcium, sodium and potassium, carbonates, nitrates, plant

extracts, starch and a laxative, for colic diarrhea, dysentery, indigestion, fevers, liver ailments, cramps, constipation, and for the prevention of scarlet fever, measles, whooping cough and diphtheria, fine \$100; Golden Peacock, Inc., Paris, Tennessee, a mouth wash represented as "highly antiseptic," "A powerful germ killer" and "ten times as strong as ordinary antiseptics," found to be not antiseptic, fine \$100 and costs.

A nominal fine of \$1 with costs was imposed by the Court on the Ferretone Company, Wichita, Kansas, shippers of "Ferretone Eye Lotion," offered for the treatment of eye ailments, and "Ferretone Tonic Tablets," offered for the treatment of various internal diseases and symptoms of disease. The Kraus-Near Chemical Company, Minneapolis, Minnesota, was fined \$50 because of a shipment of "Pep-O Iodized Dairy Minerals," represented as a treatment for diseases of cows.

False Curative Claims

Twenty medicinal preparations were picked up because of false and fraudulent curative claims on their labels. They were: "Akalyne" tablets, containing 3.2 grains of acetophenetidin and 2 grains sodium salicylate, bearing no declaration of the content of acetanilid derivative as required by the Act, and offered for the relief of headaches, neuralgia, rheumatism, menstrual disturbances, and gripe; a shipment of alum sold as a treatment for external hemorrhages and other bleedings from mucous membranes, for leukorrhea, ulcers, and sore throat; "Castrique Worm Powder," consisting entirely of sodium acetate, for worms, poor condition, unhealthy coat, loss of energy, red mange, rickets, and tapeworms in dogs.

"Colac Pile Pills," containing magnesium carbonate and vegetable material such as licorice, and coated with sugar, calcium carbonate and iron oxid, for piles and for strengthening the intestinal tract; "Grandma's Medicinal Herbs," mostly senna, with small amounts of couch grass, saffron, caraway and anise seed, licorice, sassafras, lavender, cinna-

(Continued on Next Page)

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(Continued from Preceding Page)

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"Nod," tablets containing one and one-half grains phenobarbital and two grains amidopyrin, for "naturally" overcoming sleeplessness, nervousness, restlessness, and for soothing tense nerves, and represented as "safe" despite its amidopyrin content; "Picot Compound Tablets," sodium salicylate, sodium benzoate, potassium nitrate, magnesium carbonate, uva ursi and juniper oil, for pain in the back, loins and lumbar region, rheumatic infections, neurasthenia, dyspepsia, dropsy, Bright's disease, and nephritis.

"Picot Grape-Flavored Salt," sodium bicarbonate, potassium bitartrate, tartaric acid, sugar and saccharin, with no grape flavor, represented as derived from grapes, for rheumatism and to stimulate the stomach; "Prieto Tonic," water, glycerin, 10 per cent alcohol, potassium iodid, sodium benzoate and plant drugs, including cinchona, represented as a "tonic of walnut, Mexican herbs, roots and medicinal extracts used by the Indians for many years," for insomnia,

anemia, poor blood, chronic coughs, boils, pimples, skin diseases, light ulcers, poor appetite, bronchial congestion and herpes.

"Rx 333," aspirin and sodium salicylate, for the prompt relief of pain caused by rheumatism, lumbago, neuralgia, gout, arthritis, sciatica, neuritis, and swollen joints; "Right-O Round Worm Capsules," oil chenopodium, calomel, a plant laxative, sodium bicarbonate and mineral oil, for roundworms and pinworms in pups, dogs, and foxes.

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"Ter-O-Sul," starch, sodium bisulfate, sodium bicarbonate, sulphur and other inorganic compounds, for body fatigue, weariness, sleeplessness, arthritis, sciatica, neuritis, lumbago, gout, rheumatic ailments, skin disorders, and for reducing weight; "Uriseptin," methenamin, water, glycerin, plant extracts including corn silk, alcohol and salts of sodium, potassium and lithium, offered as a urinary antiseptic, for nephritis, pyelitis, urethritis, cystitis, calculus, rheumatism, gout, pneumonia, bacteriuria, gonorrhea, gleet, and suppurative diseases of the urinary tract.

Other drug products seized were a lot of "Neo-Cultol," represented as a source of *Bacillus acidophilus* but having few such viable bacilli per teaspoonful although at least fifty million microorganisms other than the one specified; nine packages of unsterile surgical bandages, 182 ampoules of pituitary extract below the United States Pharmacopeial

(Continued on Page 26)



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(Continued from Page 24)

standard; 64 cans of impure ether, 28 dozen bottles of below-standard tincture of iodine, and 480 bottles of citrate of magnesia short in volume and not in conformity with the requirements of the United States Pharmacopeia.

More Money for Food, Spent to Better Advantage, Need of Low-Income Family.—"More money for food, and more effective application of present knowledge of food and nutrition to food-selection problems, are necessary if higher levels of nutrition are to be more generally attained by low-income city families," Dr. Hazel K. Stiebeling, senior food economist of the Bureau of Home Economics, United States Department of Agriculture, said recently in an address at the round-table conference on Nutrition and Public Health, held at the New York Academy of Medicine under the auspices of the Milbank Memorial Fund.

Summing up the results of a recent Bureau study on the diets of wage-earners and low-salaried clerical workers in North Atlantic, Southern, and Pacific Coast cities, Doctor Stiebeling said:

"Major differences in the amount and kind of food purchased by city families can be attributed to differences in the level of expense for food. With increasing expenditures for food, there is a marked increase in the total amount of all food purchased. The increases are much more marked in eggs, meats, milk, butter, and the succulent vegetables and fruits than in grain products, potatoes, dried legumes, and fats other than butter. This unequal distribution of the increases in food purchases with increasing expenditure for food results in more food for higher income groups, and in general, food richer in high-quality proteins, in minerals, and in vitamins.

"High expense for food is not necessarily a guarantee of adequate diets. The study showed that at spending levels between \$1.50 and \$4.50 per week per food-cost unit, some families managed to get 'Grade A' diets, some had 'B' diets, and others had 'Grade C' diets. (A food-cost unit is based upon the cost of the food required by a moderately active man.)

"As more money is spent for food, families tend to buy more of the milk, butter, eggs, succulent vegetables, fruits, and other foods which are good sources of the calcium or certain vitamins in which the most frequent shortages were found among the diets studied.

"Of the wage-earner families studied, about 10 per cent of those living in the North and far West, 38 per cent of the Southern white families, and 68 per cent of the negro families spent for food less than \$2 weekly per food-cost unit. About 20 per cent of the families of wage-earners in the North and far West, 6 per cent of the Southern white families, and less than 3 per cent of the negro families studied spent as much as \$4 weekly per food-cost unit.

"About one-fifth of the employed workers' families in the North Atlantic cities, an eighth of the Pacific Coast families in this same population group, 40 per cent of the white workers in the South, and 70 per cent of the colored workers were living on poor, Grade C diets, if the families studied were a typical sample.

"At 1935 price levels, apparently no families had better than C grade diets unless they were spending as much as \$1.25 in the North Atlantic region, or \$1.75 in the South, weekly per food-cost unit. Some families seemed to require as much as \$4 in the North and West, and \$3.50 in the South to secure fair or adequate diets. Average diets costing about \$3 weekly per food-cost unit in the North and West, and about 10 per cent less in the South, were at Grade A level, but less than half the families at this spending level had Grade A diets.

"In the Pacific region, a higher percentage of families at each expenditure level seemed to get good diets, and a lower percentage had poor diets, than in other regions. At every level of food expense, Pacific families bought more vegetables and fruits than did families in the North Atlantic region, about the same amount of eggs and milk, less meats, and a smaller share of their grain products in highly processed forms."

A child will learn three times as fast when he is in tune, as he will when he is dragged to his task.—Locke.

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Medical Practice Acts: Administration of Anesthetics by Nurses.—Two practicing physicians, on behalf of themselves and all other physicians, filed a petition for an injunction to restrain the defendant nurse, employed by the defendant hospital, from administering general anesthetics in connection with operations. Such practice, it was contended, constituted a violation of the Medical Practice Act of California. The trial court gave judgment for the defendants, and the plaintiffs appealed to the Supreme Court of California.

The findings, said the Supreme Court, show conclusively that everything that was done by the nurse . . . is done under the immediate direction of the operating surgeon. Such method, said the Court, seems to be the uniform practice. . . . The Court continued:

"There was much testimony as to the recognized practice of permitting nurses to administer anesthetics and hypodermics. One of the plaintiffs' witnesses testified to what seems to be the established and uniformly accepted practice and procedure followed by surgeons and nurses, and that is that it is not diagnosing nor prescribing by the nurses within the meaning of the Medical Practice Act. We are led further to accept this practice and procedure as established when we consider the evidence of the many surgeons who supported the contention of the defendant nurse, and whose qualifications to testify concerning the practice of medicine in this community and elsewhere were established beyond dispute. That such practice is in accord with the generally accepted rule is borne out by the decided cases."

Furthermore, said the Court, aside from the proposition that nurses in the surgery during the preparation for and progress of an operation are not diagnosing or prescribing within the meaning of the Medical Practice Act, it is the legally established rule that they are carrying out the orders of the physicians to whose authority they are subject. The surgeon has the power, and therefore the duty, to direct a nurse in her actions during the operation.

The judgment of the trial court for the defendants was, therefore, affirmed. (*Chalmers-Francis et al. vs. Nelson et al.* (Calif.), 57 P. (2d) 1312.)—*Journal A. M. A.*

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Medical Societies: Contract Practice in Relation to Professional Ethics.—The plaintiffs, one as its manager, were employed by the Associated Physicians Clinic, operated by two members of the King County Medical Society. This clinic made contracts with business firms of Seattle to furnish necessary medical, surgical, and hospital care to employees of such firms at a stipulated rate per month per capita. In April, 1933, the King County Medical Society organized the King County Medical Service Corporation, described in the record as "identical in its plan and operation with that of the Associated Physicians' Clinic and the other independent clinics." The following August, the medical society adopted an amendment to its by-laws, providing for the censure, suspension or expulsion of a member

"who shall engage in contract practice unless the same shall previously have been authorized by the Board of Trustees of this Society, or who as physician or surgeon shall serve on the staff of or perform work for the patients of, or shall perform work in any institution or group or organization unless such services or work shall previously have been authorized by the Board of Trustees of this Society."

Shortly thereafter the Society, it was alleged, threatened to expel the physicians who operated the Associated Physicians' Clinic unless they abandoned their contract practice. The physicians apparently continued to engage in contract practice, and on March 19, 1934, written charges were filed with the Society against them, charging a violation of the by-law quoted. The two physicians then terminated their contracts with the plaintiffs, who thereupon instituted the present suit against the King County Medical Society, the King County Medical Service Corporation and certain officers, trustees and members thereof, alleging that the defendants had caused a breach of the contract between the Associated Physicians' Clinic and the plaintiffs. The trial court sustained a demurrer interposed by the defendants, on the ground that the complaint failed to state a cause of action, and the plaintiffs appealed to the Supreme Court of Washington.

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An employee, said the Supreme Court, has no right of action against an individual or group of individuals who organize to compete with his employer. The organization of the King County Medical Service Corporation by the King County Medical Society as a competitor of the Associated Physicians' Clinic, therefore, did not create a cause of action against the defendants. Furthermore, the constitution, charter, and by-laws of the medical society constituted a contract between the members of the Society enforceable in the courts if not immoral or contrary to public policy or the law of the land. The two physicians, as members of the medical society, were required to obey the by-laws of the Society or subject themselves to the penalty of suspension or expulsion from the Society, and it is not material how selfish or unselfish the objects of the medical society may be. That the medical society had the right to adopt the by-law with respect to contract practice cannot be questioned. Whether such by-law was just, reasonable or wise, is a question of policy which concerns only the medical society and its members. The Society, in the enforcement of its by-laws for the direct purpose of benefit to itself and to its members, is not answerable for damage incidentally resulting to a third person. So long as membership in the medical society continues, the member can be compelled under his contract with the Society to obey its laws, rules and regulations, or suffer the penalty of fine, suspension or expulsion.

The enforcement of a by-law such as the one here involved, continued the court, does not amount to unlawful coercion. In *Seymour Ruff & Sons, Inc. vs. Bricklayers, etc., Union*, 163 Md. 687, 164 A. 752, it was said:

"The decisions are practically in harmony in holding that it is within the power of labor unions, and it is lawful for them, to instruct or order their members not to accept employment with an individual, or to continue in such person's employment, where the action of a union is justifiable in the sense that it is to promote the welfare of the members of the union. Accordingly, the enforcing of a by-law forbidding members of the union to serve one who has broken a contract with its members does not amount to intimi-

dation. Neither a fine or other disciplinary action under such by-law would be unlawful as to members who voluntarily subject themselves to the provision of such by-law. They are left free to enter the employment of the prescribed employer, although practically they are compelled to choose between the benefits of such employment and membership in the union."

In *Booker & Kinnaird vs. Louisville Board of Fire Underwriters*, 118 Ky. 771, 224 S. W. 451, 21 A. L. R. 531, the Court said:

"In almost every profession and every business there are associations or lodges or boards, organized by persons engaged in particular lines of industry or following certain professions, that have for their sole purpose the protection and promotion of the best interest of the business or profession in which they are engaged. And bodies like these, acting in a collective capacity, may, in a quiet orderly way when their interests demand it, refuse to deal with or have any business relations with any other person or persons they choose, although the effect of such combined action is to boycott the objectionable person. . . ."

An association, in pursuing its legitimate objects, has the right to coerce a member by fine, suspension or expulsion, and the association will not, nor will its members, be liable in damages to those who may be directly or indirectly injured by such efforts. So long as a member remains in the association, he is subject to the coercive effect of a penalty exacted for breach of a by-law of the association. If he does not desire to abide by the obligations of his contract of membership, he may abandon his membership. No rights of the plaintiffs in this case, who were nonmembers, were invaded by the medical society when it established its code of ethics and insisted on compliance therewith through threat of expulsion of an offending member, and the enforcement of solidarity by threat of expulsion of the two physicians created no cause of action for the incidental damage resulting to the plaintiffs.

The judgment of the trial court for the defendants was therefore affirmed. (*Porter et al. vs. King County Medical Society et al.* (Wash.), 58 P. (2d) 367.)—*Journal A. M. A.*

Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$—— to be known as the —— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$——, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the —— Gift, the following described real property situate in the County of ——, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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When controversy bursts forth, the first one to become silent is assuredly of good family.—Talmud.



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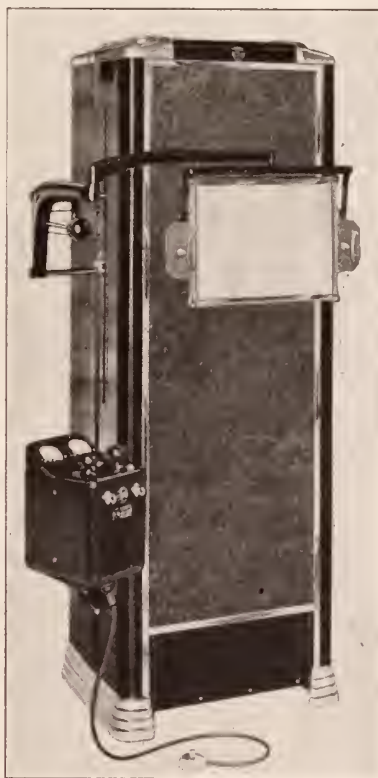
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● The summer traveler or camper frequently accepts chances of infection by *Endamoeba histolytica*. Unguarded water supplies, food prepared by unknown hands, the unavoidable presence of the housefly—all contribute to the possibility of ingestion of the cysts of this organism.

Throughout the year the physician has many occasions to consider amebiasis in the differen-

tial diagnosis, inasmuch as 5 percent to 10 percent of the population of the United States is infected. The symptoms of amebic infestation are protean and suggestive of a variety of diseases of different etiologies.

Carbarsone, Lilly (p-carbamino phenylarsonic acid), is effective in treatment, is of low toxicity, and is usually successful without supplementary medication. It may be given orally in capsules or tablets, or it may be administered by retention enema. Supplied in 0.25-Gm. pulvules; in 0.05-Gm. and 0.25-Gm. tablets; in boxes of six 2-Gm. vials; and in one-ounce bottles.

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EDITOR GEORGE H. KRESS

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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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NOTE: Because of the late date on which the minutes of the Del Monte annual session were received by the Editor, it was not possible to print this June issue of CALIFORNIA AND WESTERN MEDICINE on schedule time. The minutes being important, it was decided that delay until the July issue would be inadvisable.—G. H. K.

EDITORIALS†

THE SIXTY-SIXTH ANNUAL SESSION DEL MONTE, MAY 2-6, 1937

Del Monte Sessions in 1912 and 1937 Significant for Work Done.—Twenty-five years ago the California Medical Association held its annual session at Del Monte. Founder-Editor Philip Mills Jones' comments on the convention of 1912 apply with force as equally to the session just held, from the 2nd to the 6th of May, as when, a quarter of a century ago, he wrote:

The Del Monte Meeting.—The annual meeting of the State Society, held at Del Monte on the 16th, 17th, and 18th of last month, was in every way a distinct success. There was such a large amount of business introduced. . . . Some of the business matters brought up will be found to be of great importance to our several county societies. . . .

Throughout the session there was displayed not only keen interest in all matters pertaining to the affairs of the Society and to the business presented, but also a harmony of feeling and a total lack of bitterness or prejudice that speaks strongly for the continuance of improvement in all parts of the State.

* * *

Minutes of House of Delegates and Council: Their Importance.—All members of the Association may well take time to scan the proceedings, in outline, of the two important official groups whose function and responsibility are to speak in the name of the California Medical Association on matters of policy and procedure. For, to be indifferent in days such as the present, on how Organized Medicine is trying to solve its problems (in our State, Organized Medicine means the California Medical Association, its component county societies and members) is to invite the thought that physicians so constituted are lacking in what might well be termed their civic responsibilities in medical practice.

The well-established relationships between physicians and patients, which have worked out so successfully in the many past decades, are today being subjected to one assault after another, mostly by theorizing laymen who are usually on good salaries from subsidized "foundations," and who

†Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

ofttimes stop at nothing, in the exploitation of their vagaries through articles in the press, as they repeatedly thrust their ill-digested opinions upon the attention of the public.

Fortunately, the medical profession, with its record of altruistic service and ethical standards surpassed by no other professional or vocational group, is able calmly and with courage to meet such aggressions; in the knowledge that men and women who have consistently given their discoveries, for disease prevention and health conservation, to the world without hope of material profit to themselves, never could be, and are not indifferent to the lot of fellow citizens of humble economic station, to whom disease or injury, at times, may add additional afflictions, and concerning whose care so many irresponsible statements have been made.

If the wide influence of the press in promoting propaganda designed to poison the minds of the public and of lawmakers had not been so abundantly proved in the past, the shoutings and fantasies of these would-be exploiters of radical changes in private medical practice could be passed over as of little or no consequence; yet not, if year after year we are confronted in congressional halls at Washington and legislative chambers at Sacramento with all kinds of ill-natured and theoretic laws which, once enacted, could in most cases result only in more harm than good in matters they would presumably alleviate. This is especially evident since proposed legislation of that sort would in general wreck havoc upon those established methods of practice so long standing the test of time, in accomplishing ends, such as the highest type of medical and surgical service to the largest possible number of human beings, by a group of professional men and women who live up to a code wherein each moves forward to larger service, in proportion to his own individual capacity and worth.

What has been written above may seem to be far afield from a consideration of the minutes of the House of Delegates and Council on transactions at the recent Del Monte annual session; but not so, for it is the exploitation of these so-called needed reforms in medical practice, often placed in the public eye during the last ten years or so by lay romanticists and obsessionists, that has added to Organized Medicine the responsibilities and duties it must meet today.

Wherefore, if you would know somewhat the trend of problems affecting every physician who practices medicine in California, a perusal of the official proceedings at Del Monte will be well worth your time.*

* * *

Items of Special Interest: California Medical Economic Survey; Dues; New Officers; and 1938 Meeting Place.—The House of Delegates, as the supreme legislative body of the California Medical Association, decided two issues, in which many members have had a special interest:

1. *California Medical Economic Survey.*—The California Medical Economic Survey (so-called "Dodd Report"), in accordance with the regulations of the Federal Works Progress Administra-

tion, by instructions from the House of Delegates at Del Monte has been almost entirely dissociated from the California Medical Association, which organization, as "co- or supporting sponsor"—in the last three years, contributed some \$35,000 of its funds to carry on the work—and given over to the California State Board of Health, now according to Federal rules, the "legal sponsor."

2. *Dues.*—The State Society assessment for the coming year was reduced by the House of Delegates from the \$15 schedule, in operation for 1937, to \$10 for the year 1938. This action was taken, not because of the lack of important activities whose causes could be promoted if adequate funds were available, but for the reason that the House of Delegates wished, in the present strenuous times, to make the State Association's financial burden as low as the immediate urgency of its needs would permit.

3. *New Officers.*—In the May issue of CALIFORNIA AND WESTERN MEDICINE comment was made concerning Dr. Edward M. Palette of Los Angeles, who retired as president; Dr. Howard Morrow of San Francisco, who assumed the presidency; and Dr. W. W. Roblee of Riverside, who was honored by election to the office of president-elect.

The elevation of Doctor Roblee to his new position made necessary the selection of a Speaker of the House of Delegates, and Dr. Lowell S. Goin of Los Angeles became the recipient of this honor. Doctor Goin has long been identified with organization work in the Los Angeles County Medical Association, and his friends feel he will make for himself a creditable record in his new responsibilities. Dr. John H. Graves of San Francisco was reelected Vice-Speaker of the House.

Two retiring councilors-at-large received the unanimous approval of the House for continuance in their positions: Dr. Junius B. Harris of Sacramento and Dr. William H. Kiger of Los Angeles, whose long records of efficient service made them, logically, persons to succeed themselves.

For councilor of the third district, Dr. Louis A. Packard of Bakersfield, who in the last several years has done such yeoman service in Kern County in its county hospital fight, was selected. Dr. Karl L. Schaupp of San Francisco, who has been chairman of the Council's Executive Committee, was returned without opposition, and so, also, Dr. Henry S. Rogers, who has been most faithful in maintaining his official contacts with the component county societies comprising the ninth district.

The names of other general officers and members of standing committees will be found in the minutes.†

4. *Next Year's Session in Pasadena.*—The Hotel Huntington, at Pasadena, will be the host of next year's annual session, the date of meeting to be determined later by the Council, after the 1938 place and date of meeting of the American Medical Association are decided by the Board of Trustees of the national organization.

The problem of where the California Medical Association, with its more than 5,600 members,

* For minutes, see pages 410-429.

† See pages 415 and 416.

shall hold its annual session, is becoming an increasingly-difficult one for the officers to solve. The day is past when all members who attend can be housed under one roof, desirable as that arrangement, for convenience to section meetings and promotion of fraternal relations, may be.

The Huntington is one of the largest hotels in California, and since many Los Angeles County members will not take rooms, its spaciousness should be sufficient to house most of the out-of-town colleagues. However, in order to avoid disappointment, those who wish to be certain of accommodations should write as soon as convenient to the hotel management and make their reservations.

CALIFORNIA MEDICAL ECONOMIC SURVEY

Action of the Riverside Annual Session of May, 1934; and the Committee of Five.—CALIFORNIA AND WESTERN MEDICINE, in its issue of November, 1934 (page 344), printed an official notice concerning the California Medical Economic Survey, signed by Paul A. Dodd, Ph.D., who had been appointed Director of the Survey by the California Medical Association Committee of Five (Doctors William R. Molony, chairman; Harry H. Wilson, secretary; Rodney A. Yoell, Robert A. Peers, and Alson R. Kilgore). In that communication, attention of the members of the Association was called to the questionnaires which had been sent to the physicians throughout the State; the replies to which, when properly segregated and compiled, were to furnish material for charts, tables and graphs that would shed light on the economic and other phases of sickness in California, as interpreted by physicians in practice throughout the State.

The Committee of Five came into being through action of the House of Delegates at the sixty-third annual session of the Association held at Riverside, at a memorable session of the House that did not adjourn until 2 a. m. on Thursday, May 3, 1934. (See issue of CALIFORNIA AND WESTERN MEDICINE for June, 1934, page 431, page 445, Resolution No. 4, and page 446, Resolution No. 8.)

* * *

Survey-Director's Original Estimates Were Greatly Exceeded.—Since that time, as regards this medical economic survey, concerning the cost of which the appointed director, on more occasions than one, assured the Council (the body responsible for the carrying out of the instructions of the House of Delegates) that the sum of approximately \$14,000 would be the maximum contribution to be expected from the California Medical Association for its share of the work, "much water has gone over the dam," and many hours have been spent by the Committee of Five and the Council in trying to bring the project to completion. A sad financial experience developed from time to time, through the readjustments of estimates by the Director on the California Medical Association's share, until the total amount of Association funds expended not only equalled the sum of \$14,000, but exceeded the figure of \$35,000! And the end is not yet, for the Association, on

behalf of itself and the Federal Government (which, through the WPA, expended some \$55,000 in giving employment to field agents and workers), feels itself obligated to bring to publication a final report.

* * *

Where Much of the Delay Rested.—A considerable amount of the delay that has arisen since the work was first undertaken may be said to have come about through a wrong orientation by some of the employees of the Association as to their places and authority in the survey. (See editorial in May issue, page 290.) Since the appearance of the comments there made, last month, the 1937 California Medical Association annual session has been held, the Committee of Five, appointed in 1934, submitting its final report and being relieved, by the Del Monte House of Delegates, of further duty.*

* * *

Federal Works Progress Administration Rules Clarified a Muddled Situation.—In accordance with the March 13, 1937 rules of the Works Progress Administration known as "Operating Procedure No. W-11—Regulations for Publication of Statistical, Survey and Research Materials," wherein the legal sponsor (in the case of the California Medical Economic Survey, the California State Board of Health, because it is the State authority through which the federal moneys for the field work were dispensed), is the agency responsible for bringing the report off the press; the cooperating sponsor (in this instance the California Medical Association) having fulfilled its obligations when it provided ways and means for the housing, equipment and direction of the field and other work, and payment for the printing costs of the final report.

* * *

Final Agreement With the Federal Authorities.—In a letter dated May 13, 1937 signed by Regional Coördinator of Statistical Projects James B. Sharp of San Francisco, and addressed to the Chairman of the Coördinating Committee of the Central Statistical Board at Washington, D. C., the allocation of responsibility, as above indicated, is practically outlined.

The California State Board of Health is expediting the completion of the report and every possible effort will be made to forward its publication, in full coöperation with the federal authorities, either before the close of the present fiscal year on June 30, 1937, or within a month thereafter. The Council of the California Medical Association, too, is giving all possible coöperation and has authorized the printing of an adequate number of copies.

It is to be regretted that misunderstandings of function and authority should have crept into this project; these, unfortunately, being of such nature and amount as would give a distorted impression to many persons who (both in and out of the medical profession), not having access to first-hand knowledge of actual facts, would be naturally apt to criticize the California Medical Association for lack of joint action. Of all that, however, more perhaps, on some later occasion.

*See minutes in this issue: Item 25, p. 423; Item 17, p. 427; and Item 4, p. 428.

**STATUS OF PUBLIC HEALTH LEGISLATION:
AS IT WILL BE WHEN THE CALIFORNIA
LEGISLATURE ADJOURNS ON
MAY 28, 1937**

California Legislature's Adjournment.—California's fifty-second legislature convened on Monday, January 4, 1937, and is scheduled to adjourn on Friday, May 28, 1937, although it be necessary to stop the clock pendulums of the legislative chambers one or more days in order to permit the last of the legislative grist to go through this year's law mill.* Commencing in the January number, proposed enactments having public health bearings have been discussed in each issue of CALIFORNIA AND WESTERN MEDICINE, and at the annual session of the Association at Del Monte, Dr. Junius B. Harris of Sacramento (who, in recent years, on behalf of the California Medical Association, and as chairman of its Committee on Public Policy and Legislation, has voluntarily sacrificed no end of time and effort in safeguarding the interests of the public health and medical practice) made a report that was listened to with rapt attention by the delegates present.

* * *

Digest of Report of Committee on Public Policy and Legislation.—Even though, at this writing, it does not tell the complete story of the final days of this year's session of the California Legislature, a digest, because of the valuable information it contains, is worthy of careful reading:

With the opening of the Legislature, our first concern was the personnel of the committees which would consider public health legislation. Both Lieutenant-Governor George J. Hatfield and Speaker of the Assembly, William Moseley Jones, were very coöperative, and as a result the committees appointed are very fair-minded.

To date, 4,185 proposed laws have been introduced—an all-time record for California. We have scanned all of these bills and find over 250 have some reference to the practice of the medical professions and public health legislation. We are concerned with fifty-four committees, which meet from 8:30 in the morning until the wee sma' hours of the following morning, to say nothing of the actual sessions of the Assembly and the Senate, where measures of concern to us pop up for a vote almost every day. Subdivided by groups, we find the following:

Board of Health.—Fifteen bills were introduced relating to the powers of the State Board of Health. Representatives of the department are watching this legislation carefully.

Chiropody.—The chiropodists are sponsoring two bills to regulate misleading advertising. These have passed the Assembly and are now before the Senate.

Chiropractors.—The chiropractors have been on the job in force, as usual, trying to extend their rights through two bills. To date, both of these are buried in committee.

Clinical Laboratories.—The lay laboratories reintroduced their bill, which was passed in 1935, but found unconstitutional. It has passed the Senate and is now before the Assembly.

Code Bills.—During the past two years the California Code Commission has been busy codifying the existing laws relating to the business and professional acts of the State. These are known as the Dental Code, Medical Code, Optometry Code, etc. These bills have passed the Senate and the Assembly, and are now before the Governor for consideration.

Compensation Act.—Several bills were introduced by persons who have sought to amend the Compensation Act. Two of these were the medical and hospital-records bills, requiring records to be exhibited to the patient and any person he authorizes to examine the same. Seven others would give the injured employee free choice of healer (not confined to M. D.'s). To date, none of these bills and nothing vitally concerning the Compensation Act have been passed.

County Hospitals.—One of the hottest fights has been against three bills and a proposed constitutional amendment which would open up county hospitals to so-called "pay patients." These bills have had powerful backing from the Farm Bureau, from labor and from various boards of county supervisors, and it has only been through the united work of the California Medical Association, the Public Health League of California, the Hospital Associations, and the State Dental Associations that they have been held in check. One of them was tabled in committee; two others have failed to muster sufficient votes to emerge from committee, and the constitutional amendment has been sent back to committee.

Expert Testimony.—Senate Bill 446, sponsored by the California Medical Association, has passed the Senate and is now in the Assembly.

Health Insurance.—The toughest battle to date has been on the subject of health insurance. Two bills were introduced early in the session—one in the Senate and one in the Assembly—to set up control of voluntary health service associations in the Department of Insurance. These "companion" bills were sponsored by interested medical and "groups" in Los Angeles and San Francisco. They enlisted the support of the Farm Bureau and large groups of public employees, teachers, etc., who are subscribers to one or the other service. The Farm Bureau has made this one of its major objectives, its representative apparently giving more time to trying to regulate the medical and dental service than to promote strictly farm problems. This subject has been constantly before the Assembly Committee on Insurance since March 26. To meet an apparent demand for legislation enabling voluntary medical service insurance, the California Medical Association sponsored two bills on this subject (Senate Bill 605 and Assembly Bill 1491). Such strong objection was rendered from various sources that Assembly Bill 1491 was amended in many of its provisions, and is now before the Assembly for vote.

On May 10, the supporters of Assembly Bill 1283 (sponsored by the above-named groups) brought it before the Assembly for vote. It received twenty-four favorable votes and forty-six in opposition!

Hospitalization Insurance.—The Association of California Hospitals is sponsoring Assembly Bill 1132, designed to set up machinery for the sale of hospital service on an insurance and nonprofit basis. This has passed the Assembly, and is now before the Senate for vote.

Medical Practice Act.—Thirty-three bills proposing to amend the Medical Practice Act are before the Legislature, only seven of which were sponsored by the Board of Medical Examiners. The remainder are from outsiders who seek to dress up the Act according to their special ideas.

Naturopaths.—Developing unexpected strength, and with a well-financed organization, the naturopaths have carried on a hot campaign to enact Assembly Bill 1472, which is almost identical with the old Proposition 17 which was defeated in 1934 as an initiative. The bill was defeated in the Assembly, 16 to 49.

Optometry.—The optometrists brought up a proposal to amend their Act so as to permit them to treat eyes. When the battle was over, the "treatment" provision had been deleted.

Osteopaths.—The osteopaths have been more active and more determined at this session than ever before. They have combed every bill before the Legislature and, wherever possible, have proposed seemingly harmless amendments to present themselves to the public on the same basis as Doctors of Medicine.

X-Ray.—Assembly Bill 1009, sponsored by the Pacific Roentgen Club, was introduced on January 20, but to date it has not been taken up by committee for hearing.

* Adjourned as of that date, but actually (with clocks stopped), on Sunday, May 30, 1937, 4:15 a. m.

Status of Proposed Laws at the Time of the Legislature's Adjournment

County Hospital Opening.—Assembly Bill 51 (admission to county hospitals), Assembly Bill 1196 (county hospitals), Assembly Bill 1695 (county hospitals), and Senate Constitutional Amendment 5 (county hospitals), all died in committee.

Chiropractors.—Assembly Bill 2731 and Assembly Constitutional Amendment 35, killed in committee.

Clinical Laboratories.—Senate Bill 118 (technologists, technicians, blanket license to laboratories) passed the Senate and the Assembly, and is now before the Governor.

Codes.—All Professional Code Bills are now before the Governor.

Compensation Act.—Bills requiring exhibition of patient's records were killed in committee. All bills permitting injured person free choice of healer (not confined to M. D.'s) were killed in committee.

Expert Testimony.—Senate Bill 446 (expert testimony) passed the Senate and Assembly. Now before the Governor.

Hospitalization Insurance.—Assembly Bill 1132 (non-profit hospitalization) passed the Legislature and is now before the Governor.

Medical Practice Act.—All bills attacking this Act were killed in committee. Senate Bills 781, 782, 783 (State Medical Practice Act), introduced by the Board of Medical Examiners, providing remedies and disciplinary proceeding under Medical Practice Act, have passed the Senate.

Naturopaths.—Assembly Bill 1472 (naturopathy) was killed on floor of the Assembly.

Osteopaths in Schools.—Assembly Bill 684 (school health certificates) and Assembly Bill 1880 (school health certificates) passed the Assembly, but were killed in Senate committees. Repeated attempts to revive them have been stopped.

Venereal Diseases.—Assembly Bill 2790 (venereal diseases) passed the Assembly and Senate. Now before the Governor.

X-Rays.—Assembly Bill 1009 (x-ray) was left in committee files.

A SAMPLE OF SOCIALIZED MEDICINE PROPAGANDA: HONEST AND CLEAR-THINKING PEOPLE CAN DRAW THEIR OWN CONCLUSIONS

A Recent Article in a Lay Publication.—In the May issue of a publication which each month finds a place on some of the news stands appeared, as an opening article, an account of suffering by a man who was treated in a hospital in Los Angeles, which, because of statements made in the article, and its nature, is quite apt to be seized upon, used in portions by propagandists for state medicine, in much the same fashion as the antivivisectionists present their stories of laboratory cruelty to the lower animals. We have taken the pains to look up this particular case and present for our readers some excerpts from the article, which was written by the patient, whose description of his own sufferings, presumably, led a well-known writer to accept the same and volunteer a foreword, these also containing statements quite as startling as those made by his patient-friend or acquaintance. We shall also comment on what the records of the hospital actually show as having been paid by the patient. Readers can then judge for themselves concerning the merit of the statements of the patient, and the justification of the publicist's foreword, as based thereon.

Quotations from the Story as Narrated by the Patient.—First, some quotations from the patient's story:

August of my twenty-third year, 1926, . . . I was working as a "mud-smeller," an oil geologist, in the desert oil fields of the San Joaquin Valley, California. . . .

* * *

. . . Then one night at the bridge table—just as it can happen to anyone—wham! a pain hit me, running from hip to knee down the outside of my left leg. I was no stranger to pain, for eight years before I had smashed my leg and had to have the decayed bone removed by an operation before I made a complete recovery. . . .

* * *

. . . Marje persuaded me to try Christian Science, and to please her I honestly tried to think that what I foolishly thought of as pain was, after all, only "error." . . .

* * *

. . . Finally I gave up, went to bed and called in two physicians. . . . I made an agonizing trip by train to Los Angeles and went into a big hospital there. . . .

* * *

. . . The next day, without consulting me, he [the Los Angeles physician] dragged a bone surgeon into the case. . . .

[Later] . . . We must eliminate, he said, the possibility that I was being poisoned by bad sinuses. . . . Since I have always had some slight sinus trouble, I gave in. I wasn't being poisoned by bad sinuses, but it cost me \$80 for the x-ray of my head and the specialist to prove it.

* * *

. . . As I lay, with the pain beating dreadfully in my hip, I couldn't help contrasting the snail-like slowness of the hospital routine with the hustle and efficiency of the oil industry. Here they had taken a week to make a few tests and x-rays which I felt could surely have been completed in a day, had there been any snap to their organization.

* * *

. . . I remained another week in the hospital and then moved to a bungalow in a court. During my two weeks' stay I had improved, until I could walk without much pain on a pair of crutches. . . .

* * *

. . . Now I wanted to change doctors, but it was too late. They had picked me clean. Though they knew my salary was only a little over \$2,000 a year, they had charged me over \$300 for their first month's services. This together with the \$250 for two weeks in the hospital, x-rays, physiotherapy, \$80 for the nose doctor, and nearly \$40 for internal medicine had made my first month of sickness cost me more than I could save in two years. October's bills were less, for I had only the doctors and my internal medicine to pay. Still, by the time November's bills came I could see the end of my money. Also, I had just been told that, sympathetic as the company felt, my November pay check would have to be my last. They had worked their way through all the money I had in the bank, including \$500 belonging to my wife, three salary checks (over \$500), some oil stock, and even my Petroleum Club membership. It was no great amount—around \$1,500, I believe—but it was all we had, and the doctors certainly were far from charging in proportion to my income, as they always claim to do. . . .

* * *

Excerpts from the Foreword of the Publicist. Let us turn now to the foreword by the publicist:

In a blizzard in February, 1936, ———, who was slowly dying, came to our camp by Lake Michigan. Again and again for ten years he had been given up by small and great surgeons so that he knew his own doom, and the miracle of his still being alive has become drab to him. This snowy day he came with no hope of some new cure to which I

might direct him. Long ago I had failed him there, and my advice came near killing him quickly, not slowly, five years before. Now he wanted to write, in the short time he knew was left him, the biography of his illness that was inexorable as incurable cancer. In an hour of tragi-comic narrative he sketched an epic of human hope never quite downed by suffering or often imminent death. . . . Post-graduate in suffering that he was, he made me ashamed of the superficiality of my own stories of the human death fight. Today he has proved his plan was no day-dream. Now against the stream of the failing of his vital functions he is writing a story that cannot fail to touch the hearts and brains of men and women of good will. It reduces to absurdity solemn inquiries about costs of medical care or arguments about socialized medicine. . . .

* * *

The Real Facts as to What Was Paid.—

Now, what is the truth as to moneys paid by this patient, who was admitted to the hospital on October 18 and discharged November 5, 1926, after a period of eighteen days?

1. The superintendent of the hospital in question states that, according to its financial records, these were the accommodations afforded; and for the same and the service rendered, only the following amounts, as a total, were ever paid by the person so making the complaint:

The patient occupied a private room (not a ward bed, available at a much lesser cost), for which he paid \$8.50 per day for eighteen days, a total of \$153. Additional payments made to the hospital included:

Laboratory examinations.....	\$ 5.50
X-ray examination of pelvis and leg.....	32.00
X-ray of sinuses	15.00
Telegrams and telephone calls.....	3.60
Drugs and prescriptions.....	30.25

Grand total.....\$239.35

2. The physician, who made the diagnosis of chronic and recurrent arthritis and who sent the patient to the hospital, and who himself, or through his assistant, attended him almost daily and visited him some twenty-four times after he left the hospital, states that he did not receive a single penny for the professional services he so rendered!

3. The otolaryngologist, who visited him in the hospital and treated him in his office on some ten different occasions also states that his records show he did not receive a penny for his professional services!

4. The orthopedic surgeon's records are not available, but probably, in view of the above, it would be fair to assume that the patient, not having paid the other two physicians, most likely failed to pay the orthopedic surgeon as well.

Contrast, now, the patient's outcry as to the fees he lets his readers think he paid with these actual facts of what, through nonpayment by the person receiving the professional services, was nothing else than free treatment in a private hospital (could socialized or state medicine give as much or one whit more?), and ponder on the greatness of heart and mind of the publicist who, from this special instance, would draw the general conclusion—a well-established fallacy in logic is drawing a general conclusion for a special instance, al-

though in this case the real facts belie the premises concocted from the particular instance!—that nothing more is needed to justify the institution of state medicine than this isolated case!

If the advocates of socialized and state medicine having nothing better to rely on as factual propaganda for the exploitation of their theories than misinformation such as this, then they are, indeed, hard put to sustain their cause.

The space here devoted to these comments is given in order to acquaint members of the profession, who may have seen or heard of the article referred to, with the real, unadorned facts.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 410.

EDITORIAL COMMENT†

ACUTE URINARY INFECTIONS

An attack of acute ascending infection of the urinary tract, as characterized by frequency, dysuria, fever and, if particularly severe, chills, was until recently usually treated by the administration of urotropin, hexamethylenetetramin, or methenamin, depending upon the name under which that formaldehyd-liberating drug was dispensed. To insure the liberation of the formaldehyd, which is only given off in an acid media, acid sodium phosphate was also prescribed. This method of treatment met with failure in all cases in which the urine remained alkaline, either because of the simultaneous ingestion of alkalizing drugs or, more frequently, due to the presence of a mixed infection in which were included urea-splitting organisms which were constantly liberating ammonia. In other cases the liberation of the formaldehyd resulted in so much irritation to the urinary mucosa that the patient's symptoms were aggravated rather than improved. When such unfortunate results developed, it has been customary to reverse the process by the administration of alkalizing drugs. If the urine was already alkaline this, of course, brought no relief, while in many cases rendering of the urine alkaline made the conditions for the growth of the offending organism more favorable.

This belief in the virtues of alkalinity was based on the following: That the acidity of the urine rather than the products of bacterial growth, was responsible for the irritated urinary mucosa. In fact, the idea that increased acidity will produce untoward symptoms is so firmly fixed in the minds

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

of the profession that we find several large corporations, by a campaign of fear, proclaiming the fact in their national advertising, most soda fountains having become virtual prophylactic stations where the purchase of that universal panacea, alkalizer, is supposed to prevent the worst. The only difficulty with this situation is that it is based on total misapprehension of the facts: an acid urine is not irritating; an alkaline urine is not soothing.

If to these distracted citizens one adds the number of individuals who, by the same or similar urge, are persuaded to ingest ever-increasing amounts of pineapple, orange, and tomato juice, it is little wonder that the urologic profession is seeing more and more cases of cystitis, and the incidence of stone formation is yearly increasing; for nothing so favors the precipitation of the majority of urinary salts as a constantly alkaline media. How frequently the laity is warned against eating meat because of urinary irritation, only a urologist can appreciate. The number of individuals who have even become anemic from lack of protein digestion in the hope of relieving urinary frequency is astounding.

Space does not permit extended comment on the innumerable dyes that have been foisted on the profession as urinary antiseptics. Except for the psychic action of the various colors they develop in the voided specimen, most are devoid of any therapeutic effect, usually lacking germicidal action.

Due to the recent work of numerous investigators led by Clark and Helmholtz, we now have a rational basis for the treatment of urinary infections. The normal reaction of the urine being acid, it was found that this acidity could be increased to as much as 4.5 pH without any irritation resulting. It was further ascertained that most members of the colon group of organisms could not multiply in a media much below a pH of 5.5, and if it was still further lowered the organisms were actually killed. The acidity of the urine cannot be measured satisfactorily by litmus paper. Fortunately, today nitrazine papers will enable not only the physician but the patient to judge accurately the degree of acidity.

With this knowledge these workers suggested the production of this high acidity by the Ketogenic diet. While efficacious, this proved difficult of ingestion except under the direct supervision of a dietitian, and then few were hardy enough to stay on it for more than a week or ten days. Because of this difficulty a search was commenced to ascertain what drugs could produce a satisfactory bactericidal action by increasing the urinary acidity without the necessity of such a rigid diet. Ammonium chlorid proved of considerable benefit in the milder cases, while nitrohydrochloric was advocated by some; but, to date, mandelic acid in conjunction with ammonium chlorid has proved the most reliable. By its administration it is possible to render the urine not alone bacterial static, but actually bactericidal.

It is to be hoped, however, that the greatest good from this knowledge will be realization that the too

extensive ingestion of alkaline ash foods and drinks is distinctly injurious, and the eating of protein foods is not dangerous even in the presence of extensive urinary infection.

112 North Madison Avenue.

H. C. BUMPUS, JR.,
Pasadena.

"MEDICAL MILITARY PREPAREDNESS"

Military medicine, with its complex administrative problems and its special medical and surgical requirements, no longer interests the great body of the profession after war is over. It is, therefore, quickly forgotten, and when another war comes our profession has to start all over again, and with much delay, confusion and lost motion, receive a new education in military medicine. Dr. Harvey Cushing's "From a Surgeon's Journal" gives a graphic picture of our predicament twenty-five years ago. He impresses the point that the last war, thanks to our allies, gave us a year for preparation and protected our shores. The next war will see a different opening period.

Medicine is more valuable in military affairs than ever before, chiefly because it has more to offer. The World War was the first to have an equal number of deaths from war wounds and communicable diseases. This brought us the Carrel Dakin solution, improved thoracic surgery, the Thomas splint, a broader recognition of neuropsychiatric problems and a better conception of cardiology, but little progress in the treatment of influenza, measles, and cerebrospinal meningitis. New weapons and a general alliance between science and military affairs will extend future warfare from the battlefield to the homestead. Tomorrow's battles will entail taking care of our own neighborhoods as well as our distant (?) battlefronts.

What the next war will be like no one can say. Instead of trench warfare until exhaustion, it will more likely be consummated by sudden movements or thrusts toward the economic heart of the lesser-prepared nation. Present Army plans for two field armies will call for 47,000 medical officers. The Navy Medical Corps will expand to eight times its present strength. This will entail the enlistment of one-third of the whole civilian medical profession and probably four-fifths of those eligible will be needed. This does not include replacements. The other two-thirds will have the care of the civilian population which will present many new and difficult problems, requiring special training on the part of physicians before the onset of war.

We cannot interpret the war of tomorrow exclusively in the terms of the war of yesterday. The next war, it is believed, will be on a much greater scale, not only numerically but in the war zones covered. There will be a great demand for medical men capable of concentrating their efforts in overcoming influenza, measles, pneumonia, pulmonary tuberculosis, and neuropathic recognition of individuals with inferiority or psychopathic complexes. There will be fame for the

men who can offer an adequate treatment of mustard, thermit and white phosphorus burns.

We all remember the hurried physical and mental examinations of our troops before their departure to France. Had we had adequate medico-military preparedness, much postwar grief would have been avoided. The draft boards rejected 500,000 men and passed 750,000 who were rejected and discharged from the Army camps on examination as unfit for military duty.

The part in which the military surgeon plays the most important rôle is the selection of men for military service. We are fortunate in having a splendid Veterans' Bureau to serve as a nucleus for our next campaign. The importance of accepting men is balanced by the necessity of accurate observation by the men in charge at the end of service for postwar ratings for disability compensation purposes. About \$12,000,000,000 have been paid out in war pensions and compensation by the Government for war disabilities based on examinations by physicians.

The civilian physicians of today will be the medical officers of tomorrow. Military medicine differs from civilian practice in that it centers on two objectives—the prevention of disease and the conversion of casualties into rifle carriers. The last war brought home one great deficiency in the medical personnel—that of specialists. The hope of any man to continue in his specialty or to attach himself to a specialty in the next war, will lie in his preparation now and enrollment in the Reserve as a specialist. The formation of national boards for specialists allows acknowledged men to be correctly placed in the sphere of their greatest usefulness.

The Reserve was organized to perpetuate the framework of the organization developed in the World War. The medical veteran not only transmits his experience, but also sets an example for the younger generation in the Reserve who will in time become replacements. The various military sections, both in the Reserve and in the county medicals, might well sponsor courses in schools or forums toward medical military preparedness.

The coming convention of the Association of Military Surgeons will offer a well-balanced program along these lines. Their meeting at the Ambassador Hotel in Los Angeles, October 14-16, will be attended by surgeons from all parts of the world. The program will contain the latest information of military medicine as well as a glimpse into the future. There will be both scientific and commercial exhibits of note. Hence, members are urged to mark their calendars ahead for this timely meeting.

6777 Hollywood Boulevard.

HOWARD L. UPDEGRAFF,
Los Angeles.

Employment is nature's physician and is essential to human happiness.—Galen.

The peak of human physical efficiency is reached at about the age of twenty-four.

ORIGINAL ARTICLES

PNEUMONIAS: THEIR MANAGEMENT*

By JESSE G. M. BULLOWA, M.D.†
New York

PNEUMONIA ranks third among the causes of death. In the City of New York alone during the year 1935 there died from this disease 809 men and 292 women between the ages of twenty and fifty. If we consider the annual earnings of the males to have averaged \$2,500, the approximate present worth of the net future earnings of these men would have amounted to twenty million dollars. I shall not attempt to value the earnings of the women.

WHAT SHOULD MANAGEMENT INCLUDE?

The management of the pneumonias should include the prevention of these diseases, which are largely carried by human vectors and spread by the ordinary contacts of business and pleasure. Prevention may ultimately be by means of immunization against the viruses of the common cold and influenza, which prepare for the subsequent bacterial invasion. Eighty per cent of my cases have the history of a head or chest cold preceding the chill or chest pain which marks the onset of pneumonia. It may, however, be more important to protect against the secondary invaders, which are the primary causes of the pneumonias. The work of Felton, with a group antigenic fraction of the pneumococci, may prove of great value. It is being evaluated in the Civilian Conservation Camps at the present time. Until active immunization is perfected, reliance must be placed upon the prompt segregation and cure of those who are stricken. Vaccination against the specific organisms involved in local epidemics is recommended and was successfully practiced by Smillie.¹ He described an epidemic due to *Pneumococcus* II in a veterans' hospital, which lasted two years and ceased after vaccination of the personnel of the pavilion infected.

CURATIVE MANAGEMENT

The curative management of the pneumonias concerns especially the pneumococci, because the large majority of the pneumonias are due to these organisms. The pneumococcic pneumonias are caused by a group of organisms morphologically and culturally similar, but immunologically separate and distinct. At least thirty-two types of pneumococci are now recognized, due to the brilliant and painstaking work of Georgia Cooper.

SERUM THERAPY

The present favorable position of serum therapy is due to (1) the prompt and precise method for

*Guest Speaker paper in a Symposium on Pneumonia. Read before the General Medicine Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2-6, 1937.

†From the Littauer Pneumonia Research Fund, New York University and the Medical Service, Harlem Hospital, New York City.

This study received financial support in part from the Metropolitan Life Insurance Company and the Maurice Levin Fund.

TABLE 1.—Effect of Bacteremia on Mortality by Day of Serum Treatment, *Pneumococcus I* Pneumonias, 1926-1936

Day of Disease Serum First Given	Total Cases				Bacteremic Cases			
	Cases	Deaths	Per Cent	Error	Cases	Deaths	Per Cent	Error
One	17	0	0.0	....	1	0	0.0	....
Two	73	7	9.6	±3.5	15	4	26.6	....
Three	115	11	9.6	±2.7	17	6	35.3	....
Four	148	13	8.8	±2.3	36	9	25.0	±7.2
Five	160	24	15.0	±2.8	44	17	38.6	±7.3
Six	136	24	17.6	±3.3	35	19	54.4	±8.4
Seven	77	16	20.8	±4.7	18	10	55.6	....
Eight and later	142	31	21.8	±3.6	27	18	66.7	....
Onset unobtainable	6	2	.....	....	1	1	.....	....
Total	874	128	14.7	±1.2	194	84	43.3	±3.6
One through four	353	31	8.8	±1.5	69	19	27.6	±5.3
Five and later	515	95	18.4	±1.7	124	64	51.6	±4.5
Onset unobtainable	6	2	.....	....	1	1	.....	....
Total	874	128	14.7	±1.2	194	84	43.3	±3.6
One through six	649	79	12.2	±1.3	148	55	37.1	±4.0
Seven and later	219	47	21.4	±2.8	45	28	62.3	±7.2
Onset unobtainable	6	2	.....	....	1	1	.....	....
Total	874	128	14.7	±1.2	194	84	43.3	±3.6

identification of the responsible organism, and (2) to more adequate methods of administering potent refined and concentrated specific therapeutic sera. The determination of pneumococcus type may be made in 76 per cent of the cases by a direct Neufeld examination of the sputum. Where too few organisms are present, it may be necessary to propagate them in white mice, where they are usually found in the peritoneal exudate after three to four hours, or in the mouse blood after eight to ten hours. The organism obtained from the sputum is responsible for the pneumonia in 93 per cent of the cases, as shown by comparison with simultaneous or subsequent lung aspiration and blood culture.

ROUTINE BLOOD CULTURE

A routine blood culture should be taken to determine the presence of bacteremia, which does not always occur at the onset of the pneumonia. Most of the complications of pneumonia, as well as the deaths, are associated with bacteremia, and may be prevented by the adequate administration of serum. Large doses should be given early in the disease and the most potent serum should be used, as this gives more protection in a shorter time. With severe cases we endeavor to give the entire required dose at once, sometimes in a single intravenous drip, which dilutes the antibody, thus preventing reaction. Frequently, after a single dose of serum, there is a permanent fall of pulse and temperature, and specific agglutinins appear in the blood. The agglutinins in the blood serve as a "marker," *e. g.*, when there is very strong agglutination it is unnecessary to give additional serum, and if the pulse and temperature remain elevated another explanation must be sought. There may be invasion with an additional or a different type from that for which serum was given, a compli-

cation or serum sickness. When serum is given in adequate dose and early in the disease, there is a termination of the disease and absence of complications, and bacteremias are either prevented or cured.

COMMENTS ON RESULTS IN AN EIGHT-YEAR SERIES

The results for pneumococcus I pneumonia over a period of ten years are shown in the accompanying tables (1 and 2) which show the importance of early administration rather than the futility of late administration, and the profound influence of age and bacteremia on mortality.

In the first three years of these observations cases were alternated as they came to the service, the even-number cases receiving serum and the odd-number cases receiving no serum. In the no-serum series the mortality was 32 per cent, in the bacteremic no-serum cases the death rate was 75 per cent.

The reduction in mortality resulting from the use of serum in pneumococcus I pneumonias was also observed in other pneumonias, for which a serum of ample potency was procurable.

Our Harlem Hospital experience is not sufficient to establish statistically the value of serum therapy for pneumococcus II. However, when we combine our own with the experience of the Boston City Hospital, we find a very significant reduction in the death rate of the serum-treated cases. There were 259 cases with 120 deaths (46.3 per cent) in the non-serum treated cases, and 204 cases with 63 deaths (31 per cent) in the serum group. The difference in the death rate of the bacteremic cases is not significant. The incidence of bacteremia was higher in those treated without serum. The effect of early serum administration is shown in the table by decades. In Doctor Finland's series the mor-

TABLE 2.—*Effect of Early Use of Serum on Mortality by Decades, Pneumococcus I Pneumonias*

Age	Total Cases					
	First Through Fourth Day of Serum Treatment			Fifth Day of Serum Treatment and Later		
	Cases	Deaths	Per Cent	Cases	Deaths	Per Cent
12-19	33	0	0.0	42	3	7.1
20-29	109	7	6.4	133	12	9.0
30-39	83	4	4.8	124	20	16.1
40-49	46	8	17.4	77	10	13.0
50-59	13	4	30.8	34	15	44.1
60-69	6	2	33.3	8	2	25.0
70 and over	0	0	.....	6	3	50.0
Total	290	25	8.6	424	65	15.3
Age	Bacteremic Cases					
	First Through Fourth Day of Serum Treatment			Fifth Day of Serum Treatment and Later		
	Cases	Deaths	Per Cent	Cases	Deaths	Per Cent
12-19	4	0	0.0	4	2	50.0
20-29	20	3	15.0	29	6	20.7
30-39	14	2	14.3	30	12	40.0
40-49	9	4	44.4	18	7	39.0
50-59	4	3	75.0	18	14	77.8
60-69	4	2	50.0	2	1	50.0
70 and over	0	0	.....	4	3	75.0
Total	55	14	25.4	105	45	42.8

tality in serum cases was 50 per cent, and in my own it was 42 per cent. In the table, serum mortality was 23.6 per cent in patients treated before the fifth day. In both series the death rate of patients treated on the first three days was only 20 per cent.

With serums for pneumococcus V, VII, and VIII, and a number of other types, such as XIV and XVIII (given in ample amount so as to very rapidly saturate the blood), the death rate is reduced significantly and the disease is terminated as dramatically as it occurs when serum is used in pneumonias due to pneumococcus I. Over a period of seven years at Harlem Hospital the death rate in pneumococcus V has been 20 per cent; when strong serum was given in sufficient amounts, the death rate was reduced to 11.5 per cent when a moderately potent serum was used (780 units per cubic centimeter) and to 5 per cent when a very potent serum (3100 units per cubic centimeter) was employed.

In pneumococcus XVIII the death rate over a period of eight years has been 26 per cent. In the serum-treated cases it is approximately 6 per cent. Of twelve cases of bacteremia which received no serum, nine patients died. Only one of five cases treated with serum died.

When adequate amounts of serum do not cause a termination of the disease, as evidenced by fall of pulse and temperature, it is because there is (1) a mistyping and the serum is not specific, (2) a second invading type, (3) a complication due to the type involved, or (4) serum sickness from the serum used. This leads to a discussion of adequate dosage. Adequate dosage is sufficient serum given in a short period to sensitize every organism. It cannot be expressed for every patient in cubic centimeters or units. If some organisms

are not sensitized, there is always an opportunity for them to escape into the circulation and multiply. I contrast two cases of pneumococcus VII pneumonia. One, where small doses were given to a bacteremic patient in whom there was a temporary recession of the bacteremia and ultimately a multiplication of the cocci, which was not controlled by later doses of serum. Another patient entered with pulmonary edema on the eighth day of her disease. She had 300 colonies per cubic centimeter of her blood; 400,000 units of concentrated rabbit serum was given. The organisms multiplied and the next day 700 colonies were found. The dose of serum was repeated, and she received 1,800,000 units; the blood stream became sterile and the patient is well.

THERAPEUTIC RABBIT SERUM

A recent development is the employment of therapeutic rabbit serum. This has certain advantages. It has in many instances a greater initial potency before concentration. The protective antibody is in the water-soluble fraction, and is part of or associated with a smaller molecule than in horse serum, so it may penetrate tissues which are impenetrable for horse serum. No prozone has been observed, and it is not inactivated by certain common lipids. Because of the smaller animal and the more rapid production of antibody, it may be possible to have serum for types which would not be made if it were necessary to rely on horses. Two varieties of rabbit serum are being studied. Through the courtesy of Doctors Goodner and Horsfall of the Rockefeller Institute Hospital, I am using a processed serum which has had the chill factors largely removed by heating to 58 degrees for one-half hour, and by absorption with washed kaolin. This preparation gives few chills when preceded by aspirin. The other is a concentrated rabbit

TABLE 3.—*Effect of Early Use of Serum on Mortality by Decades, Pneumococcus II Pneumonias*

Age Group	Serum Before Fifth Day			Serum Fifth Day or Later			Non-Serum Mortality		
	Cases	Deaths	Per Cent	Cases	Deaths	Per Cent	Cases	Deaths	Per Cent
12-19	5	0	0.0	6	1	16.7	6	0	0.0
20-29	19	2	10.5	17	5	29.4	35	9	25.7
30-39	15	5	33.3	23	13	56.5	31	12	38.7
40-49	11	5	45.5	12	3	25.0	20	12	60.0
50-59*	3	1	33.3	3	2	66.6	12	7	58.3
60-69	2	0	0.0	1	1	100.0	4	2	50.0
70 and over ..	.....	.....	.....	.....	.....	.....	3	2	66.7
Total	55	13	23.6	62	25	40.4	111	44	39.7

* Additional death. Day unknown.

serum; preparations containing 20,000 units per cubic centimeter have been made. Although fewer patients seem to be sensitive to rabbit serum than to horse serum, it is impossible to test for sensitivity to rabbit serum by the dermal reaction because a skin reaction is frequent. Sensitivity is tested by administering a small amount, one-tenth cubic centimeter in five cubic centimeters of saline intravenously. If there is less than 20 millimeters fall of blood pressure after five minutes, the patient is not sensitive.

Allergy to other than the specific serum is not a contraindication to the use of serum. We give horse serum to patients suffering from asthma when the asthma is not due to horse serum.

It is of great value to possess antibodies for the different types of pneumococci in two animals, so that when a patient is sensitive to one the other may be used, but it is not essential.

Patients may be sensitive to sera from two animals.

REPORT OF CASE

A high-school boy, age sixteen years, took suddenly ill at 10 a. m. on April 9, 1937, with generalized aches and pains, malaise, cough with occasional expectoration of clear sputum, fever and headache. He stayed at home in bed. With the onset of the illness, he felt nauseous and could not eat.

April 11—10:30 a. m. Acutely ill, in no distress with hot, dry skin, moist tongue and injected pharynx. Chest: Lungs, vesicular respiration throughout, occasional crepitant râles over right lower lobe. Abdomen soft; no distention. 11 p. m.—Blood culture was negative.

April 12—9 a. m. The patient persists in complaint of pain in abdomen. Sputum bloody, tenacious; no organisms. Blood culture was negative.

April 13—9:45 a. m. Chill. The patient had cough productive of blood-streaked sputum. Pain in left lower chest. Over left lower lobe, dullness to percussion, bronchial breath sounds, bronchophony, and crepitant râles. Neufeld Pneumococcus I. Blood culture was negative.

2:30 p. m.—Blood culture was negative.

Sensitivity to horse serum.

4 p. m.—Ophthalmic—Sclera became injected after five minutes. Intradermal—Saline negative, horse serum 1:100 in two minutes, large urticarial eruption around injected area; wheal two centimeters in diameter surrounded by erythematous ring, four centimeters in diameter. Reaction caused itching over entire forearm. No systemic reaction.

O₂ with nasal inhaler at four liters per minute.

X-ray—Increased density of left lower lobe.

8:30 p. m.—Blood culture was negative.

April 14—12 noon. Bronchial breathing over left lower lobe. Diminished breathing over left upper lobe. Mouse Brain—Pneumococcus I.

SERUM SENSITIVITY TEST: RABBIT SERUM

1 p. m.—Rockefeller Rabbit Serum Processed, Pn. I, Lot No. 2.1.6. One-tenth cubic centimeter in five cubic centimeters physiological saline, given intravenously.

Blood pressure before injection was 108/50; pulse, 100; respiration, 32. Blood pressure two minutes after injection was 70/50; pulse, 110; respiration, 36. After injection the patient wanted to sneeze, became dyspneic. 1:02 p. m.—The patient became restless, dyspneic and cyanotic; musical râles throughout entire chest, profuse perspiration, pulse thready, urticarial eruption over face and arms. Edema of eyelids. The patient was given one cubic centimeter of adrenalin and O₂ at eight liters per minute. Condition improving slowly.

Therapeutic rabbit serum injection by Doctor Horsfall.

April 13—8:45 p. m. Infusion of 5 per cent glucose in normal saline begun, six cubic centimeters (180 drops) per minute.

8:48 p. m.—Adrenalin subcutaneously, M IV. All intravenous injections given into tube 18 inches from vein.

Hour	Dilution in Normal Saline	Time
8:55.....	0.5 cc. serum to 20 cc.....	23 min.
9:21.....	1.0 cc. serum to 20 cc.....	7 min.
9:32.....	2.0 cc. serum to 20 cc.....	6 min.
9:40.....	4.0 cc. serum to 20 cc.....	4 min.
9:46.....	8 cc. serum to 20 cc.....	4 min.
9:54.....	16 cc. serum to 20 cc.....	6 min.
10:04.....	20 cc. serum no dilution.....	6 min.
10:12.....	20 cc. serum no dilution.....	4 min.
10:18.....	20 cc. serum no dilution.....	3 min.
10:22.....	20 cc. serum no dilution.....	4 min.
10:26.....	7 cc. serum no dilution.....	½ min.

11 p. m.—Shaking chill lasting ten minutes.

Temperature before chill, 102.4; pulse, 100; respiration, 30.

One-half hour after chill—Temperature, 105.4; pulse, 110; respiration, 32.

Next morning—Temperature, pulse, and respiration were normal.

COMMENT

As you may gather from the data presented, the early use of specific serum terminates the pneumonia. In many of my patients who have received serum on the first or second day, the patients are discharged on the eighth or ninth day completely recovered and feeling able to work.

Sulfanilamide has been used in some of the pneumococcal pneumonias. There is evidence that it may be of value for its bacteriostatic action in patients suffering from pneumococcus III. Three cases, from whose blood a few colonies of pneumococcus III were recovered, received sulfanilamide and recovered. Two patients with heavy invasions

did not recover, although there had been a temporary diminution in the number of organisms. The drug is not without deleterious side effects. It may depress bone-marrow function and reduce the activity of leukocytes. It causes sulfhemoglobinemia evidenced by severe cyanosis. In one case 6 grams of the 15 grams of hemoglobin per 100 cubic centimeters of blood (about 40 per cent) was so converted. The patient had a ghastly aspect for several days after the drug was discontinued.

In some communities, and in some epidemics, streptococcic pneumonias may be of great importance. Pneumonias may be induced by *Streptococcus alpha* or *Streptococcus beta*, but very rarely by *Streptococcus gamma*. The pneumonias due to *Streptococcus alpha* have been either very mild or have induced empyema. In one patient a brain abscess developed. Pneumonia due to *Streptococcus beta* may be due to one of the twenty-seven different types of Griffith. Where the types which cause scarlet fever are present, convalescent scarlet fever serum has induced a critical termination. This serum did not, however, prevent development of empyema. The streptococcic pneumonias cause early pleural effusion. We have also had excellent results in pneumonias due to *Streptococcus hemolyticus* from an adequate administration of sulfanilamid, especially in those cases where an organism has been recovered by lung suction, and the blood culture has been sterile.

IN CONCLUSION

Unfortunately the precise diagnosis of pneumonia, including the type, may not be made until several days have elapsed. Under such conditions, much larger doses of serum must be employed, and opportunity for marked disturbances in metabolism and destruction of necessary body ingredients have occurred.

A thorough knowledge of physiology and pharmacology is required for the treatment of pneumonia. There is no disease where the emergencies are more sudden and more menacing. Because of the consolidation of the lungs, ability to absorb oxygen is restricted. The oxygen deficiency leads to changes in the circulation and the nutrition of the brain, so that restlessness and delirium are frequent. In addition, through the skin and gastrointestinal tract there may be marked losses of water and salt, and exhaustion of hormones leading to loss of tissue turgor. On this account there must be a careful selection of sedatives, while extreme vigilance is exercised in nursing and feeding.

SUMMARY

The management of the pneumonias depends upon etiologic differentiation, and a serotherapy is available which saves lives and shortens illnesses. Serotherapy and chemotherapy are available for the *Streptococcus beta*. The principles involved in serotherapy and chemotherapy are indicated.

62 West Eighty-seventh Street.

REFERENCE

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THE PRACTICE OF PEDIATRICS AS A SPECIALTY*

By E. B. SHAW, M.D.
San Francisco

THE pioneers of pediatrics, a small and scattered group, are only the immediate predecessors of most of us who comprise the second group in this specialty. Ours is a young specialty, and in our generation we have been enabled to observe a great part of its development and definition, many things which constitute the chief activities of the present-day pediatrician, have been developed during this time.

Pediatrics is a direct outgrowth, or at least a concomitant development, of a new idea in intensive puericulture. The old scheme of rearing children was based on the sound biologic law of the survival of the fittest. Children were produced in abundance and an effort was made to supply them with their needs for subsistence but they thrived or not, survived or not, largely dependent on their own inherent powers in the struggle for existence. This older method is biologically sound but economically not so tenable. Thereby was produced a hardy race of survivors, a certain percentage of cripples, and many of the weaker were removed by natural processes.

The modern method is based on a desire for smaller families, accomplished by methods of birth control, with the idea of giving every individual maximum opportunity for obtaining his best possible degree of development—physically, mentally, and culturally. During the last two or three decades the average span of life has been materially lengthened; this result has largely been secured through improvement of health and nutrition during the early years of life. The ultimate result of the improved care of childhood on the physical status of later life is still to be demonstrated but it is not unlikely that there will be unpredictable remote effects in the later years of future generations as the result of such an extensive biologic experiment. Not long ago the chief problems of child health were the product of scarcity of certain essentials, our generation has created some new problems of superabundance.

Formerly most children were born at home—as a matter of fact were delivered sight unseen beneath the bedcovers. This resulted in poor obstetrics and primitive asepsis but only the fittest were expected to survive and asepsis was not nearly so important as later when cases were crowded into hospitals. The mother nursed her baby as a matter of course. As long as she had sufficient milk she needed very little help with the nutrition of her baby and gradually maternal nursing was supplemented by casual additions from the family table. Of course, if the mother's milk supply was inadequate the problem of artificial feeding was extremely complicated and hazardous, and infant mortality in these cases was appallingly high.

* Chairman's address before the Pediatrics Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2-6, 1937.

The babies which comprise your practice and mine are delivered in hospitals. Modern obstetrics and better prenatal and postnatal care have led to a great diminution in the hazards of very early life. The obstetricians learned their lessons in the prevention of infection from Semmelweis and Oliver Wendell Holmes and similar lessons have had to be learned by the pediatrician in the care of infants in the socialized atmosphere of the nursery. A curious by-product of this system has been, however, a marked decrease in breast feeding. In most mammals, including until the last few years the human being, the young are nursed almost incessantly during the first few days of life. Gradually, as the milk supply becomes established, a more convenient schedule is established. This procedure fits poorly with hospital routine. The hospital baby is nursed most infrequently during the first few days and is then generally put upon a final schedule of widely spaced nursings. This results poorly in the establishment of adequate milk supply. Meanwhile the baby is subjected to repeated weighings and there is great and perhaps unnatural concern about his weight increment. Almost inevitably the baby is placed partly or entirely on artificial food somewhere between the first hour and the first week of life. This is entirely inimical to the natural method of feeding an infant; it is not necessarily bad, but it is distinctly abnormal. Quantitatively, of course, the nutrition of the infant is thus improved but qualitatively there is the possibility of far-reaching effects. Colostrum has some effect on the bodily economy of the new-born. Does its absence adversely affect the immunologic status of the individual? The introduction of foreign protein into the digestive tract of the infant is not well borne by most animals and is not always well tolerated by the human being. I cannot help wondering if the apparent tremendous increase in allergy can be thus explained. San Francisco should be an ideal laboratory in which to test this hypothesis. The effect of interference with maternal nursing cannot readily be evaluated; one must reflect on the results of this on the mother both physically and emotionally. The muscular effort of nursing the breast differs entirely from that of taking the bottle, the former requiring an amount of muscular activity of the jaws at variance with their rôle in the latter which almost certainly affects the development of the baby's jaws and teeth. Many of the defects of dental occlusion, currently attributed to thumb-sucking and the use of soft food are thus more rationally explained. Pediatrics must face all of the possible effects of substitution of the artificial for the physiological. It is unlikely that the artificial can preferably supplant the physiologic; proof in support of this will require far more observation than is at our present command. It is, further, most unlikely that a profound biologic change in the mother has suddenly, in one generation, rendered so many unable to nourish their infants.

Nearly every authoritative treatise on infant feeding begins with the precept that breast milk is

the best food for the infant. So explicit is this dictum that, rather surprisingly, the manufacturers of artificial food use it as a slogan—with, of course, the implication that theirs is the next best food. If this be true and not idle pious platitude the pediatrician would do well to adopt a program better fitted for its accomplishment. Infant feeding has become so simple as not to require extreme skill—the superior qualifications of the specialist might much better be devoted to the more difficult problem of breast feeding if it is not heresy to advocate it. Our grandmothers, who nursed their babies because they usually otherwise would die, nursed them frequently at first and never gave artificial food until it was an absolute necessity, followed, in my opinion, a program much more likely to achieve this result than is brought about by pre-lacteal feeding, supplementary feeding with cow's milk, and frequent early abandonment of breast feeding.

Our knowledge of artificial feeding has meanwhile perforce greatly improved. Our knowledge of the quantitative requirements of an infant has especially progressed but knowledge regarding the qualitative requirements has not progressed so rapidly. Undoubtedly, the greatest improvement in the mortality rate of artificially fed infants has resulted from the production of uncontaminated milk and the application of aseptic methods to the preparation of a formula. The qualitative adaptation of cow's milk to the infant's nutrition has not been nearly so well perfected as the principle of giving the baby enough to eat. Mother's milk contains all of the food factors essential to nutrition; cow's milk, especially when it has been heated to destroy pathogenic bacteria and for preservation, does not. Improved knowledge regarding accessory food substances, the vitamins, has gradually improved to reach what we may trust to be a climax at the present time. Gradually vitamins A, B, C, D, and upward have been added to the infant dietary with increasing enthusiasm. Thereby certain diseases produced by deficiency in these vitamins have been gradually eliminated but at the present time these substances are exhibited with such enthusiasm that one must fear the possible effect of superabundance. This problem is particularly acute in the case of vitamin D which the modern infant receives by way of that naturally present in his food, through artificial reinforcement of the content of the milk, by cod-liver oil, other fish oils, and viosterol, and by solar radiation. In all probability the organism is capable of rejecting an excess but we must at least consider the possibility of adverse effects of overdosage. These effects may not be apparent in the first few years of life and may not sufficiently be demonstrated by a single generation of experience. It is unlikely that many children have been overdosed with synthetic vitamins but it is sincerely to be hoped that there will be nothing in the future to reproach present over-enthusiasm.

In the feeding of children past early infancy, pediatrics has gone through several phases. With

improved knowledge of the quantitative requirements of the infant and child we early began to set up a strict standard of nutrition which was indiscriminately applied. For a few years mothers thrust down unwilling throats the exact amount of food prescribed for the child and the scales assumed unnatural importance in evaluating the child's nutrition. This led to a rather curious psychological problem which developed in both mother and child, and led to the absurd problem of the child who will not eat which has been discussed by most pediatricians and all psychologists. In spite of the pediatrician who said that he built his house with the child who will not eat, modern pediatrics has come to recognize that this is a problem which does not naturally exist, but is only an unfortunate by-product of an unnatural system of feeding. We have gradually come to a recognition of the fact that the nutrition of a child must be individually judged. Some are large, some are small, some are fat, some are thin. Every pediatrician should hang above his scales the poem of the little elf man, "I am just as big for me, said he, as you are big for you." The dietary components for the child have been altered materially in the last few years. Not so long ago children received solid food during the first year, mostly surreptitiously. Then came the period when children were given, long after the appearance of their teeth, only soft, sloppy foods and some children never did really learn to chew. More recently solids of almost every kind and of increasing solidity have been added to the diet at earlier and earlier time to a present almost unnatural extreme. The incorporation of vitamin components in the diet of older children has also been carried to ridiculous extremes.

The influence of scientific advance is to be seen not only in the field of nutrition in this matter of intensive puericulture. Past infancy the child is receiving more scientific attention than in any previous time in the world's history. Most of this effort is, doubtless, on the whole beneficial, and is partly responsible for the tremendous improvement in nutrition, stature, and general well-being of our present-day children. But pediatrics must not attempt to gild the lily, the purpose of periodic health examinations is to maintain a state of health in the individual, and not to elevate him to a state of supernutrition. It is the wise pediatrician who can counsel the mother without providing her a complete substitute for her own common sense and maternal devotion. It will be well if the phrase, "the triumph of technique over reason" which has been leveled at some other specialties, can never properly be flung at pediatrics.

The energetic application of specific immunization in communicable diseases has been an outstanding development of modern pediatrics. The prevention of smallpox rests on a century of experience which demonstrates its usefulness, effectiveness, and safety most convincingly. During the past thirty years, experience has demonstrated that

diphtheria can be prevented by a method which is not directly analogous to smallpox vaccination, but which even more thoroughly complies with essential criteria. These methods have engendered an enthusiasm which has led to the introduction of numerous methods designed for the specific prevention of communicable disease. It is utterly essential that before such methods be generally applied there should be adequate evidence regarding the criteria of usefulness, effectiveness, and safety of each individual measure considered solely on the basis of its own merits and not by way of an analogy. One must constantly maintain a critical point of view and must be mindful of the fact that there is a practical limit to the number of such procedures to which a child should be subjected.

Our interest in the well child has not stopped with his physical well-being, the study of child psychology has progressed enormously in the past few years. Surely, no one would wish to deny that this field has contributed much to the rearing and education, to the correction of defects in personality, and to the adaptation of the child to his environment. The greatest danger in this particular sphere is that the intensively reared individual be shaped by many and inexperienced hands. The physician, especially the pediatrician, must be adequately grounded psychologically, but no scientific subject has been more popularized and at the same time more obfuscated to both the physician and the public by an intricacy of technique and terminology. Most of the psychological problems of childhood can be handled by most simple methods based on a thorough and sympathetic understanding of the child. The pediatrician who realizes how frequently physical defects are remedied by the natural processes of growth and development must not lose sight of a similar natural mechanism for the correction of psychological defects. The psychological problems of childhood, as pointed out by Brenne-
man, are seldom static.

Whatever the value of pediatrics to the well child, pediatricians must be equipped to deal even more expertly with the ill child. Almost none of the problems of diagnosis in childhood and only a few therapeutic procedures are beyond the scope of the adequately trained pediatrician. A good definition of a specialist is one who attempts only that which he does expertly. Pediatrics, in contrast to other specialties, restricts itself not to organs, systems, or to kindred diseases but to the particularized study of patients during a restricted age period. The pediatrician must bring to this pursuit certain prerequisites of knowledge which differentiate him from the internist who may be equally familiar with the disease processes themselves. He must be adequately schooled in growth and development, and must properly understand the practical aspects of child psychology, but he must be possessed of no less keen clinical sense than the internist and must, furthermore, combine his scientific qualifications with personal attributes of kindness and gentleness.

The most difficult, as well as the most interesting and important, diseases which fall within the scope of pediatrics, are the communicable diseases. The specialist in pediatrics must be exceedingly well trained in this field, for here come a great many of his emergency problems in which the outcome is greatly influenced by the promptness and accuracy of his diagnosis and treatment.

One of the greatest opportunities in pediatrics is that of clinical research conducted along the methods suggested by Sir James Mackenzie. The child is an ideal subject for the type of accurate and detailed observations necessary for the scientific study of disease and is altogether unrivaled by any experimental animal. In childhood, disease problems usually present themselves as entities unaccompanied by the numerous complicating factors which obscure observations in the adult. The pediatrician sees his patients frequently from birth to adolescence and can trace the beginnings of disease, as well as the modifications brought therein, by growth and development. Here are to be found the recognizable first-infection forms of tuberculosis and rheumatic fever; we should be alert to detect similar first-infection forms of other diseases important to adult life. Some of the most profound problems of modern medicine are more likely to be solved by the pediatrician, if he is sufficiently alert, than by any other specialist.

These clinical problems are numerous, but can be aptly illustrated by one or two examples. In the child is to be observed the interplay of endocrine influences as they affect growth, developmental changes, and the catalysis of sexual maturity. The problems of endocrine deficiency or of superabundance can be observed from their inception, the problem of therapy is thus made far more hopeful, and the opportunity for scientific study is infinitely superior to the static end-result which is presented to the observation of the internist.

Another clinical research in which the pediatrician must maintain interest and in which he has enormous opportunity in the field of his own practice is the problem of allergy, the mysterious mechanism of altered reactivity which is important to almost every field of medicine. Allergic problems which present in later life are extremely complex, in childhood one confronts the problem in its simplest guise. Only the pediatrician has the opportunity to follow the child through years which permit him to observe the modifications brought about by heredity, prenatal state, nutrition, environment, nervous influences, infection, the response to therapy, and the multitude of factors which influence the problem before it reaches the internist later on. I do not believe that there is any greater opportunity presented to the modern pediatrician. One cannot escape the conviction that the accumulated laboratory data lacks only an ingenious clinical approach to open the door to tremendous advances in our knowledge. I am convinced that a continued and truly scientific study of this condition in clinical pediatrics should be far more productive of valuable conclusions than

any similar expenditure of energy in older patients or in experimental animals.

It is, I think, unlikely, that the pediatrician will quickly be supplanted by any other type of medical practitioner. The public has been trained to demand intensive care of a restricted output of children. Continued survival of our speciality necessitates, however, that the pediatrician bring to his task highly specialized attributes of training and skill. Artificial feeding of infancy has been so simplified and standardized as no longer to make the greatest demand on this skill. The pediatrician must keep abreast of changing trends and be prepared to meet a multitude of demands in every aspect of child care, nutrition, disease prophylaxis, psychological guidance, and must offer a superior technique in the treatment of the ill child. The scientific advance of this specialty will be greatly served by proper appreciation of the extraordinary opportunities in this field for clinical research.

384 Post Street.

PERTINENT COMMENTS ON ANESTHESIA*

By HARRY J. SMITH, M.D.
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KNOWLEDGE concerning a fact goes through certain phases. These are: Discovery, appreciation, and investigation. Knowledge of anesthesia, being a fact, went through this same process in development.

Anesthetic agents were known many years before their practical application, but at last came the discovery of the fact and their use quickly followed. During the next phase, or that of appreciation, the use of ether became quite universal. It seemed so safe and satisfactory that no great effort was put forth to find anything better.

The "A. A. A." that nurtured modern surgery—anaesthesia, antisepsis, and asepsis—never needed a court decision to prove their constitutionality. They were proved beyond a doubt by their benefit to mankind.

However, anesthesia lagged behind in the rapid development of medical and surgical science. Whether due to a false sense of safety or not, the administering of ether was delegated to others who did not have the scientific training of the surgeon. Abroad that was not the case, perhaps because chloroform (which was more popular) was recognized as a dangerous agent when used by the unskilled and, therefore, was never let out of professional hands. During this phase of anesthetic knowledge, surgery made great advances in technical skill and mechanical devices to assist in operations. Also, surgical science was advanced by extension of medical curricula and development of clinics, while a few lectures sufficed to stimulate a

* Chairman's address before the Anesthesiology Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2-6, 1937.

zest for further enlightenment of the student in anesthesia.

INVESTIGATION AND RESEARCH WORK AT THE PRESENT TIME

Fortunately, we are now entering or progressing in the phase of investigation and research. During the years 1880 to 1903, much work and experimentation was carried on relative to the placing of drugs and solutions near or into the spinal canal. Spinal anesthesia was the outcome, and directly many agents were tried and various techniques used. After a few years, accumulated statistics pointed a discouraging finger at this method, and it was not until more information and less toxic drugs were available that the revival of spinal anesthesia became general.

The use of gaseous agents depended on accurate mechanical devices, lack of which handicapped the development of nitrous oxid and ethylene. The ingenious brain of the late E. I. McKesson—and we may well pause to honor him—produced some of the lacking facilities. Others followed, until now we have the means of regulating doses of gases with exactness.

PROPAGANDA FOR NEW PREPARATIONS

At present, we are in the midst of a flood of literature and frequent, but not unwelcome, visits of detail men proclaiming the virtues of their brand of sedative, analgesic and anesthetic, for oral, rectal, and intravenous use. We hardly hear of these before their use in thousands of cases are reported, and some of our colleagues, without special knowledge of anesthesia, are carried away by the description of the ease and simplicity of the drug being exploited, and are frequently rewarded with unsatisfactory or disastrous results. Here may be a good place to mention another observation. New appliances that are constantly superseding those in use are demonstrated a time or two to anesthetic technicians and, without further instruction, the salesman leaves them to develop skill in using the machine on a human being who is paying for expert care. The use of such a potent gas as cyclopropane has been tried in these devices by the same technicians with little, if any, knowledge of its pharmacologic or physiologic action.

PROCEDURE IN CAPE TOWN, SOUTH AFRICA

Perhaps such a situation as exists in Cape Town¹ might tend to put anesthesia on a sounder basis. There the anesthetist is put on the defensive and is charged with all possible accidents, and has to vindicate himself in a public trial following a police postmortem examination. The newspapers make capital of the misfortune, and the gossips have a ready-made subject for conversation. It would, at least, be a novel experience for an anesthetist hereabouts to be of enough importance to be discussed over the teacups!

THE PROBLEM OF THE NONMEDICAL ANESTHETISTS

Whatever reasons exist for nonmedical anesthetists have been discussed many times. The financial profit to hospitals is the main one. The only argument against professional anesthetists that I have

heard was that there were not enough graduates in medicine interested in such a specialty to properly handle the situation. In the third largest center of population in California, the writer knows of several doctors who looked longingly at such a career and finally abandoned it because the hospitals were practicing medicine by employing technicians and making a profit on the work they did. By this procedure the advancement of the science, as well as the living, for members of our profession are stymied.

Frank H. Lahey² says: "The training of men in anesthesia has not kept pace with the other progress in this field. Hospitals will ultimately realize that the present attitude regarding relatively low-cost anesthesia will prove a penny-wise and pound-foolish policy. Certainly, one of the present practices in anesthesia should be condemned: in the light of the present progress in anesthesia, it is quite wrong for hospitals to show a profit by charging for nurse anesthetists, even though this profit is utilized in other departments of the hospitals—if there should be a surplus income for anesthesia, it should be devoted to that for what it is paid by the patient, that is, the best anesthesia possible and the training of better anesthetists."

Why not devote more time to the teaching of anesthetic technique in nursing schools, if that training is all that is necessary in producing a proficient anesthetist? At least a better course in medical curricula would be a help to those who chose surgery as a specialty, since by recent decision they are directly responsible for the supervision of the technician in the administration of the anesthesia as well as the outcome.

Arthur M. Wright³ says: "The progress of anesthesia as a specialty has been apathetic. For this apathy the medical school has been chiefly responsible, the surgeon particularly and the anesthetist specifically." Again, he says: "Changes and experiments must come, and future advances must be made with confidence and promise. The surgeon must walk, arm in arm along the road of clinical efficiency." Let us see how this "arm in arm" procedure works out in California. Quoting from the decision of the Supreme Court of May 18, 1936: "The findings, which are amply supported by the testimony in this case, show conclusively that everything which was done in the present instance, and is generally done in the administering of anesthetics, was and is done under the immediate direction and supervision of the operating surgeon and his assistants. . . . We are led further to accept this practice and procedure as established when we consider the evidence of many surgeons who supported the contention of the defendant, and whose qualifications to testify concerning the practice of medicine in this community and elsewhere were beyond dispute."

WHY A MORE COÖPERATIVE PROFESSIONAL UNDERSTANDING SHOULD EXIST

The "road" along which such an "arm-in-arm walk" proceeds certainly will never advance the science of anesthesia, and will not bring to the surgeon's patients those benefits to which they are rightly entitled. The only way in which the surgeon

and anesthetist can walk "arm-in-arm" is on a basis of equality, not on the basis that the surgeon is in the "immediate and direct supervision of the anesthetist's work." In other words, the anesthetist should be a specialist with whom the surgeon can discuss problems as he would with an internist, and one in whose hands he would confidently leave his patient after his diagnosis and operative procedure were determined.

ENCOURAGING SIGNS

Perhaps we should not be discouraged by the slow development of our science as a specialty. There are certainly many encouraging events happening, and these events are being spaced by shorter intervals. Never was there a time when the search for new agents was so keen. In the pharmacology and physiology departments of our medical schools there is a renaissance of interest in the anesthetic problem. Several centers are open to those who would pursue knowledge and skill in the art. The genius of inventors has placed at our disposal more accurate mechanical equipment for administering inhalation anesthesia, and through accumulated statistics and writings are brought the views of others on the various drugs and methods of administering them.

The growth of our societies has been steady, and if we read aright there is a growing interest in anesthesia throughout our own country, as well as abroad.

Our great achievement will be to continue to do our best to relieve suffering and to render painless these ordeals, both natural and accidental, that come to our fellow man.

3115 Webster Street.

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SURGICAL PRACTICE: LOOKING FORWARD*

By JOHN HUNT SHEPHARD, M.D.
San Jose

THE ideals of the medical profession always have been, and always will be, beautifully expressed by an inscription over the amphitheater in old Rush Medical College, which reads: "Dedicated to the relief of suffering and the prolongation of life."

ETHICAL CODE OF PHYSICIANS

For centuries the medical profession has marched forward under its self-established principles of ethics, which are quite incomprehensible to the average layman. In essence, these principles may be summarized in three words: "Service to humanity." From time to time, down through the centuries, we find slight glimmering reflections of these principles in various crafts, trade-unions and industry, but never without the stronger light of selfishness almost completely obliterating these reflections.

*Chairman's address before the General Surgery Section at the sixty-sixth annual session of the California Medical Association, Del Monte, May 2-6, 1937.

Health is the greatest personal and national asset; yet we, the purveyors of health, are being told that we are incompetent to direct the distribution of our knowledge and service, even though we have made the United States the healthiest country in the world—a country where the highest attainments of medical service, both preventive and curative, are available to each and all who will accept of our services, and at a price within their ability to pay.

I do not believe there has ever been an individual denied medical service on account of his or her lack of material worth. It has been this willingness on the part of the members of our profession to serve their fellow man that is largely responsible for the periodic attacks made by the self-styled "social altruists" to attempt to crush us under their heel and make us subservient to their fads and fancies.

Unfortunately, there have always been and always will be members of our profession unwilling or unable to see the light or, if seeing, unwilling to follow through the portals of sacrifice and devotion so necessary to their calling.

The progress we have made (and our journey will never end) has been the result of working together, of our organized efforts for the public welfare, of the daily living according to the ideals set forth in our principles of ethics; and if these are ever forsaken, our value to humanity will drop like the value of tampered currency.

EARLY LEGAL REGULATIONS OF MEDICAL PRACTICE

A glance at the early legal regulations of the practice of medicine is not only interesting, but is evidence that the thoughts I wish to submit for your consideration were in the minds of men as long ago as 1736. The earliest legislation pertaining to the practice of medicine enacted in this country was passed by the colony of Virginia in 1639, and concerned that much discussed question of today, "medical economics." It provided that it should be lawful for any person believing the charge of a physician or surgeon to be unreasonable, to have such physician or surgeon arrested, and cause him to be brought before the proper court where he should declare upon oath the true value, worth and quantity of his drugs, and medicines administered to or for the use of the patient. The court thereupon allowed the physician or surgeon such fee as in its discretion it found fit.

From this it is logical to assume that even at this early period of our Colonial settlement there were those who felt that medical service should be provided at the expense of the state, namely, by some form of taxation.

In 1736 the Virginia Assembly passed an act regulating the fees and acts of "practitioners in physic." This act may well be considered the first legal recognition of specialization in the practice of medicine, since it made a distinction between the charges of "surgeons and apothecaries," whose training had been limited to serving an apprenticeship to those trades, and those who had studied physic in any university and taken a degree therein.

FIRST MEDICAL PRACTICE ACT: MASSACHUSETTS COLONY

The colony of Massachusetts in 1649 enacted the first measure regulating, in any way, the practice of medicine. This act may be considered as the origin of the judicial ruling which requires a physician to adhere to the principles and procedures recognized as proper by his fellow practitioners. It forbade "chirurgeons, midwives, phisytians or others to treat patients contrary to the known approved rules of art, without the advice and consent of such as are skilled in the same art, or at least some of the wisest and gravest then present."

There is no definite evidence who the sponsors were of the above first two legislative acts, but the act of the colony of Massachusetts was sponsored by members of the medical profession.

NEW YORK'S INITIAL CODE

On June 10, 1760, the General Assembly of New York enacted the first well-considered Medical Practice Act. It applied only to the city of New York, and in part reads: "No one whatsoever shall practice as a physician or surgeon in the said city of New York before he shall first have been examined in physick and surgery, and approved of and admitted by one of His Majesty's Counsel, the judges of the Supreme Court, the King's Attorney General and the Mayor of the city of New York for the time being, or by any three or more of them, taking to their assistance for such examinations such proper person or persons as they in their discretion shall think fit"; and it provided that to any candidate satisfactorily passing the examination, a testimonial of his examination and admission should be issued.

In 1792 the State of New York enacted the first law specifying certain educational requirements of applicants for medical licensure. This act provided that the applicant should have had a two years' course of study under a recognized physician, after having had a college education, or a three years' course of study without a college education; and if he possessed a medical degree from an American college or university, he was not required to secure a license.

The other colonies and states in rather rapid succession passed similar laws, and at frequent intervals the educational prerequisites for medical licensure have been increased until, today, these requirements have reached a height undreamed of fifty years ago.

PRESENT-DAY STANDARDS

To many it may seem that our present requirements for licensure are now high enough; yet I am certain that eventually and rightfully they will be raised, and these new and higher standards will be brought about by the action of the organized medical profession.

The young men and women who are now being admitted to the practice of medicine are better trained and qualified than those of us who entered practice thirty years ago. The individual knowl-

edge possessed by the older men of today has been gained partly through continued study since graduation and partly from their mistakes, some of which are marked by marble monuments which might appropriately bear the inscription: "Sacrificed for the acquisition of knowledge that in years to come will save others." Is the fact that recent licentiates are better qualified than I was when a license was granted me in 1904 justification for them to be permitted to engage in all branches of the practice of medicine and surgery as soon as they have finished one year of internship?

APPENDICITIS MORTALITY

No doubt you have read statistical reports during the last two or three years showing that the general mortality from appendicitis has been rising in recent years. You who are master surgeons have not experienced a rising mortality in your own work; yet you surgeons are seeing more and more cases requiring reoperation and frequently are finding that the original operation was either incompletely performed or accompanying pathologic processes had not been attended to. A few years ago, in reviewing 304 operations for the relief of duodenal ulcer, I found that 17 per cent of the patients had been subjected to an appendectomy within the immediately previous four years for the relief of the same group of symptoms which caused them to undergo the second laparotomy.

STANDARDIZATION OF SURGICAL PRACTICE

Surgery is something more than cutting and sewing, and having the patient leave the hospital by the front door. We have made great improvements in our hospitals through our efforts of standardization, and now inexperienced men may open and close the abdomen with a low operative mortality rate; but the pathologic laboratories of even our standardized hospitals contain far too great an array of specimens of normal tissue. It reminds one of the early days of abdominal surgery when a snowball in hell was almost as secure as an ovary in New York.

Is it not time for us to begin to standardize surgeons? Is one year of a rotating hospital internship, with three months spent as a second assistant in the operating room, sufficient training to justify granting to that man a license to do surgery? Or does an additional year of internship, magnanimously spoken of as a "year of residency," qualify one as a specialist?

Time sees many changes. Requirements which were proper and just twenty-five years ago may not be sufficient today. Twenty-five years ago there was little opportunity for a young man to be associated with a master surgeon. Even today there are less than one hundred and fifty positions yearly available in the United States for surgical fellowship. However, I believe there is another way of offering training to those young men desirous of becoming surgeons—less efficient and requiring a longer period of time than a surgical fellowship in a teaching institution, nevertheless possessing possibilities very little utilized today.

APPRENTICE AND MASTER SURGEONS

Would it be asking too much to seek the grading of surgeons into apprentice and master surgeons, requiring, except in extreme emergencies and isolated communities, the presence of a master surgeon at all operations? There are at the present time a few hospitals where the work of the junior members of the staff, until they have demonstrated their ability, is carefully watched and supervised by the senior members, and, strange as it may seem to some, the position of junior surgeon in these institutions is eagerly sought. At the present time only closed staff hospitals can enforce such a procedure. If such is proper, its endorsement by organized medicine will greatly hasten its widespread adoption.

Senior surgeons must become more sympathetic with and helpful to the younger men. Too frequently we find inexperience assisting inexperience, not because the young man who has been entrusted with the patient's welfare does not desire the assistance of an experienced surgeon, but because the experienced, established surgeon refuses to assist; yet perhaps he, himself, has acted as an assistant to the same young man only a few months previously when the youth was his intern or resident. What makes this difference of attitude? Who is to blame?

Some believe, or at least claim to believe, that if they are to assume any of the responsibility, they must assume all and take complete charge of the case. Can we not learn a lesson in charity, humility and service from our brother internists who gladly assist the young physician in obscure and difficult cases, yet allowing the young man to retain his position as the doctor in charge? I lovingly remember how Drs. E. Willys Andrews and L. L. McArthur acted as my assistants during my second year of internship and helping me to realize what a valuable service during my earlier years of practice, both to me and to my patients, it would have been could I have had a master surgeon looking over my shoulder, giving me words of advice and encouragement, and ready and willing to step in when the going became too tough for me.

IN CONCLUSION

Much study of, and changes in, the curriculum of our medical schools is being made. Is it not proper that the supervision of an embryo surgeon should continue after he has served his one or two years of internship? Postgraduate supervision, if you wish to call it such, should, I believe, continue until, figuratively speaking, the youth is safe to fly alone. Such supervision can continue if those who have been through the fire of experience cast aside their selfishness and follow that portion of the Hippocratic oath which binds one to "hold my teacher in this art equal to my own parents, to consider his family as my own brothers, and to teach them this art if they want to learn it; to impart precept, oral instruction and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physicians' oath."

Medico-Dental Building.

INFLUENZA: THE SAN FRANCISCO
OUTBREAK OF JANUARY-
FEBRUARY, 1937*

By J. C. GEIGER, M.D.

AND

J. P. GRAY, M.D.
San Francisco

DISCUSSION by Benjamin W. Black, M.D., Alameda;
William J. Kerr, M.D., San Francisco.

ACCORDING to personal telephone communications, influenza occurred in several cities in eastern and middle-western United States, notably New York, Chicago, and Denver—during late December and early January—to an extent described as "bordering on epidemic proportions." During this same period, the reported incidence in San Francisco was well below the "expected normal."¹

As many as five cases of influenza per week had not been reported in more than nine months prior to January 1, so that the higher reported incidence for San Francisco for the second week in January (ending the 9th) (24), although still below the "expected normal" level (41), was of definite significance, apparently; for the reported cases for the third, fourth, and fifth weeks ran markedly higher (317, 720, 737), with a definite decline during the sixth week (first week in February) (497).²

REPORTS RECEIVED

As expected, the reporting of influenza, during this period as in others, was grossly incomplete. It is believed, however, that the reported cases may serve as morbidity data of some value as epidemic indices. The latency that exists between the dates of onset and of reporting is a variable of no little importance, an impression frequently confirmed in the current series. The true incidence, obviously, will be some function of the reported cases, by dates of onset. It is apparent from such a tabulation that the elevated incidence in San Francisco actually antedated New Year's Day, with a gradual rise through the first eight days of January (thirteen to thirty-one cases daily), with a sharp increase (53, 62, 90, 105) to a peak on the eighteenth day (144). For the half month between January 10 and January 25, the consistently high level of approximately one hundred cases daily was maintained (minimum of 78 to maximum of 144, mean of 106). The decline was as sharp as the incline, dropping to less than ten cases daily by February 1.

QUESTION, WHETHER IT WAS INFLUENZA

Quite naturally, one asks: Was the affection reported really influenza? In the absence of detailed epidemiologic case investigation, of clinical

* From the Department of Public Health, city and county of San Francisco.

¹ The expected normal represents the mean number of cases reported or deaths recorded for the week or month, based on the nonepidemic years of the previous seven years' period, adjusted to population.

² The total of 497 cases reported included many in which the dates of onset preceded the dates of reporting by varying periods. The decline was actually much more precipitous than the weekly totals indicate.

laboratory data, and of experimental research directed at the recovery of the virus of influenza from nasal washings in early cases, by passage through the ferret, the answer to this question is obviously unsatisfactory. From clinical impressions, however, there can be little doubt that San Francisco experienced an outbreak of influenza. Fortunately, the disease was mild in its course, apparently, although debilitating in its effect in a high proportion of those affected. The more important symptoms and signs included: general malaise, moderate fever, absence of physical signs of pulmonary involvement, evidence of upper respiratory infection, leukopenia, and marked general weakness of the skeletal musculature. Gastro-intestinal disturbances were, also, not infrequent.

Added support for the premise that the outbreak was one of influenza is found in the reflection of increased morbidity in the general crude mortality rate and the specific rates for acute lobar pneumonia, bronchopneumonia, heart disease, and influenza. The weekly crude death rate fluctuates considerably, of course, as a result of the effects of small numbers and of short periods of time. Over a period of years the dispersion has been between the minimum of eight and the maximum of eighteen, with the usual swing occurring within a smaller range, between the limits of nine and fifteen. During the first six weeks of the present year, however, the rates have been 16, 14, 19, 23, 25 and 21, significantly higher than the expected rates. During these same weeks, 1,571 deaths were recorded, as contrasted with an expected normal total of 1,156. The increase in influenza mortality was first noted for the third week (ending January 16), when seven deaths were recorded as compared with the expected normal of three. The succeeding weeks showed: 19 as compared with 2; 27 as compared with 2; and 17 as compared with 3. The numbers of deaths due to acute lobar pneumonia ran parallel to those resulting from influenza, by weeks, again beginning with the third week: 14 deaths (expected normal of 7); 16—6; 31—6; and 14—8. Bronchopneumonia, likewise, as a cause of death, showed figures of almost identical significance: 9—5; 22—7; 23—9; 19—8.

Perhaps even more striking are the data related to heart disease as a cause of death: 78—52; 107—55; 110—45; 83—52. Heart disease, during recent years in San Francisco, as in several other cities, has been involved, with increasing frequency, as a cause of death. In fact, the number of deaths attributed to heart disease, week by week throughout the past year, has consistently been above the expected normal. In only eight instances, however, has the ratio of recorded deaths to expected normal been above 1.5, and in no one week did the number of deaths recorded as due to heart disease exceed seventy-one, facts which indicate that the higher weekly rates during the early weeks of 1937 were significant.

COMMENT

Of definite interest to the student of these data is the fact that there was a period of cold weather in the San Francisco Bay area during this same interval. Several standing records for low temperatures were broken by those registered during the month, with below freezing readings quite frequent. The combination of low temperatures, with high humidity and rather high velocity movement of air, in the California climate works a real hardship on certain population groups. Such conditions are expected, and appropriate precautions are taken in other parts of the country, but such weather changes in California are more than "distinctly unusual." Whether these weather changes are related to the incidence of influenza, acute lobar pneumonia and bronchopneumonia is subject to debate, obviously; but it is believed that the weather changes are definitely related to the elevation in heart disease mortality because of the inability of the person already handicapped by heart disease to meet the sudden demands of increased metabolism incident to low temperatures and high humidity.

On the basis of past experience and the meager data available in this outbreak, the prediction was made in the public press before the end of the fourth week in January that the outbreak would be definitely on the decline during the first week in February (sixth week of the year), a prediction which, fortunately, was accurate in being fulfilled.

San Francisco then experienced an outbreak of influenza during the early weeks of 1937, in which about 2,300 cases were reported. The increased reported incidence of the disease, though incomplete and inaccurate, served as an index of value in predicting the course of the epidemic. Morbidity was definitely reflected in mortality, with significant elevation of rates for influenza, acute lobar pneumonia, bronchopneumonia, and heart disease, with the highest general mortality rates recorded in San Francisco since the pandemic of 1918-1919.

101 Grove Street.

DISCUSSION

BENJAMIN W. BLACK, M. D. (Medical Director of Alameda County).—The paper by Doctors Geiger and Gray is most timely, presenting some very interesting facts, and draws some pertinent conclusions covering the subject so ably discussed. The experience on the east side of the San Francisco Bay, in Alameda County, parallels very closely that reported by Doctors Geiger and Gray for San Francisco. One is impressed, however, with the fact that there were probably more cases of influenza than actually reported. The reason for this state of affairs appears to be that physicians hesitate to report cases unless a diagnosis is definitely established. Sometimes symptoms last for several days, and the patient is very much debilitated without a positive diagnosis of influenza having been made. Some of these cases seem to present grave complications when they later appear, particularly in public hospitals.

This paper in itself will tend to make physicians more conscious of the problem, but it is to be expected that all cases of influenza will not be reported until there is a more simple manner of making diagnosis with less complicated studies having to do with the epidemiology of the disease. It is fortunate that the disease was mild; but in spite of this statement there were many complications in the cases as found later in public hospitals. For example, in January,

1937, there were fifty-five cases of influenza admitted to the Alameda County Hospital, with seven deaths, complicated by pneumonia; one complicated by a cardiac condition, and one complicated by a genito-urinary condition. In February, 1937, this number was reduced to twenty-one cases, and one death with a heart complication. In March, 1937, three cases were admitted, with no deaths.

By contrast, influenza cases admitted to the Alameda County Hospital during the months of January, February, and March of 1935 show six cases, with no deaths. During the same months in 1936, there were eight cases, with no deaths. In January, 1937, there were eighty cases with bronchopneumonia, and fifty-two deaths; eleven of these were complicated with influenza and other respiratory conditions. In February there were eighty-two cases, with nineteen deaths; nine complicated by respiratory conditions. In March fifty-three patients were admitted, with fourteen deaths; three complicated by respiratory conditions.

Certain precautions might be taken in order that the incidence of influenza, acute lobar pneumonia and bronchopneumonia might be abated, and to reduce mortality by protection against marked changes in temperature. It is to be expected that similar outbreaks will occur in the future, and the paper is timely, as it points to these influences which affect the records of this disease.

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WILLIAM J. KERR, M. D. (University of California Hospital, San Francisco).—Most clinicians agree with the authors that the outbreak of respiratory disease which occurred during the first weeks of the current year was influenza. In general, the symptoms and signs were identical with those seen during the great pandemic of 1918 and 1936. The recent outbreak, however, was similar to that of 1936 in that the number of complications did not seem to be very great. In our own experience at the University of California Hospital, among students, staff and the employees, we were struck by the number of persons who showed *Staphylococcus aureus* in nasopharyngeal cultures at the time of admission with the disease. We believe that this was of importance in the character of the complication where *Staphylococcus aureus* empyema was observed in two individuals. The increased number of deaths from pneumonia and heart disease was to be expected in the face of such an outbreak.

I did not hear any reports of influenza or some similar disease among the swine during the current season, but in 1936, in several parts of the State, there was an outbreak of a disease similar to influenza among the swine. As Doctor Shope has pointed out in his experimental work, the two diseases are closely related and almost identical. Doctor Shope feels that the uncomplicated disease, influenza, which he believes is due to a filtrable virus, is not a serious disease, but the joint effects of the virus with the bacteria present in the individual produce the clinical picture which we call complicated influenza. Pfeiffer's bacillus, however, is not constantly present in man as a somewhat similar organism is present in swine, complicating the virus disease.

Preventive measures are not yet available for the general population, but it is to be hoped that in the near future we shall have a preparation or vaccine which will protect individuals from the primary disease. There is fairly good evidence that the immunity lasts for a considerable period of time, which would be of importance in protecting the population at large.

The authors bring up the question of exposure to the weather during the recent outbreak. The relationship between such outbreaks and the weather seems to be a very close one, but it is difficult to state what conditions are necessary to bring about the disease. It is possible that the underlying factor in this case is probably a virus, is present more or less generally, and that overcooling or unusual strain upon the mechanisms of the body responsible for the control of temperature, and the water balance, are put to such a strain that they fail to function properly. The great increase of respiratory diseases during the changeable or colder winter months quite likely is related to the physical changes in the environment and their effects upon the organism in general. Whether specific immune substances are reduced to such a point that bacterial agents or viruses can attack the individual more readily under the circumstances, is open to question.

BLACK WIDOW SPIDER BITE*

REPORT OF FORTY-FOUR CASES

By H. M. GINSBURG, M.D.

Fresno

DISCUSSION by William J. Kerr, M. D., San Francisco;
Emil Bogen, M. D., Olive View.

SINCE the last report of Frawley and Ginsburg¹ there have been treated at the General Hospital of Fresno County forty-four additional bona fide cases of black widow spider poisoning. No case is listed in this report unless the patient was able accurately to describe or present the spider. If there was any doubt, the case was classified as an insect bite.

In all there have been treated at this institution ninety-six cases. The majority of the previous fifty-two cases and all of the forty-four cases herein reported received the same treatment, which will be given in detail. The literature² contains reports of cases with fatal terminations. In our entire series there were no fatalities, and in the last forty-four cases none were even critically ill. Table 1 gives a brief summary of the patients who were treated.

SITE OF BITE

This is of special interest. The area where the bite occurred was carefully inspected in the majority of cases. If seen early, the only evidence was a slightly reddened area which was not elevated, and in most cases exhibited no tenderness. If seen three to four hours after the bite, nothing was visible at the site of the bite. In the majority of cases the bite occurs from the buttock down, due to the use of outdoor privies. A few cases received bites on the upper extremity levels.

SYMPTOMS

These differ with the region bitten. A typical course of events following a bite on the buttock, penis or scrotum would be as follows. The patient experiences a bite which is sharp and smarts slightly. Within one-half to two hours a cramping sensation is noted traveling down the thigh and up the abdomen. This is then followed by severe pain in the abdomen, together with some nausea and vomiting. There is slight headache in some cases. The ache in the thighs becomes very painful and extends to the legs and feet. The patient then presents himself for treatment, complaining of excruciating pain in the abdomen, cramping pains in the thighs, legs and feet, malaise, nausea, vomiting, slight headache, and a general feeling of not being well.

If the bite occurs in the upper extremity the pain radiates to the shoulder levels first and then down toward the kidney region, with involvement of the abdomen, but not to the same extent as when bitten on the scrotum. The headache and malaise are more marked, but the nausea and vomiting are not so marked.

DIAGNOSIS

It is very important that a correct diagnosis be made. The patient bitten, when examined, pre-

* From the General Hospital of Fresno County.

TABLE 1.—Summary Concerning Forty-four Patients (*Black Widow Spider Bites*)

Name	Age	Sex	Occu- pation	Site of Bite	Presenting Complaints	Length of Stay in Hospital	Termi- nation	Blood Count	Urinary- sis	Blood Pressure	Tem- pera- ture	Pulse	Respi- ration
A. B.	14	M.	Student	Not given	Tenderness, pain in abdomen and legs	24 hours	Well	Not done	Not done	160/70	98.8° F.	86	20
L. T.	24	M.	Laborer	Penis	Abdomen rigid, no tenderness; red area on penis	48 hours	Well	14,100 white blood cells. 76 percent polymorphonuclears, hemoglobin 70 per cent	1.025, acid, 1 plus albumin	125/80	99° F.	96	20
T. C.	25	M.	Laborer	Penis	Abdominal pain, malaise; abdomen rigid	24 hours	Well	Not done	1.021, acid, 1 plus albumin	120/80	99° F.	96	20
P. M.	51	M.	Laborer	Not given	Abdominal pain and tenderness	38 hours	Well	Not done	1.031, acid, negative	135/90	98° F.	78	20
E. P.	41	M.	Rancher	Left big toe	Sharp pain over epigastrium and at site of bite; acute urinary retention	27 hours	Improved	Not done	Not done	120/80	98° F.	72	20
F. F.	70	M.	Wood cutter	Left leg	Left leg swollen, one day; small skin abrasion	26 hours	Good	Not done	1.017, acid, negative	140/80	98.4° F.	70	20
T. M.	61	M.	Laborer	Not given	Not given	24 hours	Not given	Not done	Not done	Not done	98.8° F.	80	20
L. M.	23	M.	Laborer	Back of neck	Pain in back of neck, weak legs, respiration difficult, clammy skin and rigid abdomen	24 hours	Improved	11,750 white blood cells. 84 percent polymorphonuclear- leukocytes	Not done	Not done	99° F.	68	24
R. B.	14	F.	Student	Buttocks	Chills, sweats, vomiting, nau- sea and abdominal pain	36 hours	Improved	Not done	1.020, acid	124/80	99.2° F.	100	24
W. P.	41	M.	Laborer	Penis	Pain in lower extremities, tes- ticles, chest and abdomen	56 hours	Good	Not done	1.010, acid	160/110	98.6° F.	70	22
A. J.	29	M.	Laborer	Back	Nervous, thirst; pain over kid- ney regions and chest	50 hours	Improved	Not done	1.031, acid	110/90	98.2° F.	80	19
J. V.	47	M.	None	Left toe	Pain in left toe, thigh and left region of body	92 hours	Improved	Not done	1.024, acid	145/90	99.2° F.	84	20
H. H.	27	M.	Laborer	Right arm	Pain in extremities and ab- dominal cramps	32 hours	Improved	11,250 white blood cells. 74 percent polymorphonuclears, 70 per cent hemoglobin	1.020, alkaline	140/80	98.8° F.	82	18
W. S.	34	M.	Laborer	Left lower extremity	Pain up the back, groins and epigastrium; flushed	36 hours	Improved	9,100 white blood cells. 64 percent polymorphonuclears, 80 per cent hemoglobin	1.020, acid	120/85	98.8° F.	68	19
F. E.	36	M.	Laborer	Left shoulder	Pain in left leg and shoulder; abdomen not tender	22 hour	Good	6,800 white blood cells. 75 per cent hemoglobin. Poly- morphonuclears not done	1.022, alkaline	120/80	98.6° F.	72	18
H. T.	16	M.	Student	Right cheek and leg	Dull ache in back and extremi- ties	52 hours	Good	17,500 white blood cells. 92 percent polymorphonuclears, 6 per cent lymphocytes. Red blood count 4,566,066	1.020, alkaline	140/100	99° F.	80	20
B. H.	23 months	M.	Infant	Both thighs	Pain in abdomen and extremi- ties	48 hours	Improved	Not given	Not given	None	99.6° F.	120	28

B. M.	20	M.	None	Penis	Pain in abdomen and chest; vomiting	24 hours	Improved	7,860 white blood cells, 72 percent polymorphonuclears, 80 per cent hemoglobin 28 per cent lymphocytes	Not done	130/80	98.6° F.	80	20
C. S.	75	M.	None	Back, neck	Headache, pain in back and neck; abdomen rigid	24 hours	Improved	5,000 white blood cells, 50 percent polymorphonuclears, 70 per cent hemoglobin 50 per cent lymphocytes	1,010, alkaline	170/70	98.6° F.	72	18
C. N.	29	M.	Laborer	Palmar aspect, left thigh	None	12 hours	Improved	(No laboratory work)	.....	120/80	98.8° F.	68	18
A. S.	42	M.	Mechanic	Left testicle	Pain in scrotum, arm pits, shoulders and legs	120 hours	Improved	6,200 white blood cells, 75 per cent hemoglobin, 65 per cent polymorphonuclears	1,020, acid	156/110	98.8° F.	82	20
S. G.	48	M.	Laborer	Scrotum	Pain over scrotum, legs, heart and left side of head; rigid abdomen	48 hours	Improved	Not done	1,009, alkaline	120/80	99° F.	70	18
E. C.	21	M.	Laborer	Right scapular region	Abdomen rigid, no pain	36 hours	Improved	Not done	1,029, acid	130/100	98.6° F.	72	18
J. S.	29	M.	Miner	Right knee	Pain from bite, down leg and abdomen on right	8 hours	Improved	16,150 white blood cells, 70 per cent hemoglobin, 82 per cent polymorphonuclears	Not done	140/88	98.8° F.	78	22
M. R.	20	M.	Laborer	Second right toe	Pain, right toe and up back	18 hours	Not given	Not done	Not given	140/90	99° F.	82	20
J. S.	16	M.	School boy	Not given	Pain in leg, shoulder and arm	80 hours	Good	8,500 white blood cells, 56 percent polymorphonuclears, 80 per cent hemoglobin	1,019, alkaline	140/100	98.6° F.	84	20
A. F.	30	M.	Laborer	Left leg	Pain in leg and arm; headache and pain in back	32 hours	Improved	11,400 white blood cells, 74 percent polymorphonuclears, 80 per cent hemoglobin	1,022, alkaline	135/80	98.6° F.	70	20
E. R.	16	F.	House- work	Right thigh	Pain in right and left legs down to feet	52 hours	Improved	10,350 white blood cells, 66 percent polymorphonuclears, 80 per cent hemoglobin	1,013, acid, pus cells	130/90	98.8° F.	84	18
R. A.	25	M.	Farm- hand	Dorsal surface right arm	Pain in right arm	13 hours	Improved	Not done	Not given	120/80	98.8° F.	84	18
R. L.	12	M.	School boy	Left chest	Pain in left hand, arm, chest and right lumbar region down to legs	14 hours	Improved	Not done	Not given	135/70	99.2° F.	80	22
J. H.	34	M.	Rancher	Right hip	Abdominal cramps and pain; pain in back	8 hours	Improved	Not done	Not given	140/80	98.8° F.	70	20
A. T.	27	M.	Laborer	Not given	Not given	24 hours	Improved	16,650 white blood cells, 77 percent polymorphonuclears, 75 per cent hemoglobin	1,010, acid	Not given	99° F.	74	20
E. B.	25	M.	Soda fountain work	Not given	Not given	24 hours	Improved	Not done	1,025, acid	Not given	99° F.	74	20

(Continued on Next Page)

TABLE 1.—Summary Concerning Forty-four Patients (Black Widow Spider Bites) (Continued)

Name	Age	Sex	Occu- pation	Site of Bite	Presenting Complaints	Length of Stay in Hospital	Termi- nation	Blood Count	Urinary- sis	Blood pressure	Tem- pera- ture	Pulse	Respi- ration
A. S.	17	M.	Laborer	Foot	Aching over body, headache, chills and vomiting	72 hours	Improved	16,900 white blood cells, 93 percent polymorphonuclears, 80 per cent hemoglobin	1.010, acid	140/100	99° F.	86	20
N. W.	26	M.	Laborer	Right gluteal region	Pain in left thigh and leg radiating to abdomen down back to the right leg; abdomen rigid and cramps	10 hours	Improved	Not done	1.004, neutral	135/85	98.2° F.	82	20
A. W.	34	M.	Laborer	Right shoulder	Abdominal cramps, lumbar region and leg pain	24 hours	Improved	6,600 white blood cells, 72 percent polymorphonuclears, 75 per cent hemoglobin	Not done	140/90	99.4° F.	78	20
B. C.	24	M.	Laborer	Right thigh	Numbness in right leg, back weak and abdominal cramps	72 hours	Improved	19,000 white blood cells, 90 percent polymorphonuclears, 75 per cent hemoglobin	Not done	160/120	99.2° F.	90	20
J. B.	19	M.	Laborer	Right ankle	Pain in thigh, cramp in abdomen and chest	20 hours	Improved	Not done	Not done	140/70	98.8° F.	94	21
J. B.	22	M.	Laborer	Penis	Cramps in lower abdomen; vomiting	24 hours	Improved	Not done	Not done	120/72	99.6° F.	88	20
A. E.	29	M.	Laborer	Scrotum	Pain in abdomen and legs	110 hours	Improved	4 plus Wassermann	Not given	145/90	99.2° F.	86	24
C. N.	30	M.	Laborer	Left thigh	Pain in groins and legs	30 hours	Improved	Not done	1.008, acid	132/80	98.8° F.	80	24
F. W.	16	M.	Laborer	Left foot	Pain in abdomen and chest	64 hours	Improved	Not done	1.005, acid	110/65	98.6° F.	68	20

sents an abdomen not unlike and very similar to that seen in ruptured peptic ulcer. No doubt numerous cases have been operated for ruptured ulcer. Lobar pneumonia, angina pectoris, renal colic, enteritis, acute appendicitis, volvulus of stomach, acute pancreatitis, coronary thrombosis, and food poisoning, must also be differentiated. A careful history and examination are essential. In the cases seen here the abdominal rigidity following a bite is board-like, simulating a ruptured ulcer, the differential points of which are as follows:

Spider	Ulcer
(a) Positive for bite.	(a) Negative for bite.
(b) No ulcer history.	(b) Ulcer history
(c) Course of spread from bitten area to abdomen.	(c) Knife-like pain at point of rupture.
(d) Mild or no collapse.	(d) Collapse.
(e) Temperature normal or slightly elevated.	(e) Temperature subnormal.
(f) Pulse slightly faster.	(f) Pulse usually normal.
(g) Abdomen rigid.	(g) Abdomen rigid.
(h) Cramp of extremities.	(h) No cramps of extremities.
(i) X-ray negative for gas bubble.	(i) X-ray evidence of gas bubble in majority of cases.
(j) Can sit up or move about.	(j) Remains very quiet—Does not want to be moved.

The temperature, pulse, and respiration show very little differentiation from the normal to be of any prognostic value. The blood pressure, aside from those found in aged individuals, were well within normal limits. The blood analyses were not constant enough to be of great value, although it seems that a slight elevation does occur in the white blood cells and polymorphonuclear leukocytes.

TREATMENT

A routine treatment is used, as described previously, and consists of the following:

1. Morphine sulphate, grain one-quarter, hypodermically.

2. Magnesium sulphate, a 20 cubic centimeter ampoule of 10 per cent solution is given intravenously, to be repeated if necessary.

3. Fluids freely.

4. Amytal, grains iii, for restlessness.

5. Absolute bed rest for twenty-four hours.

6. Glucose, 10 per cent, intravenously if patient's condition demands it.

RESULTS

In this series the average length of stay in the hospital was 37.3 hours. In the majority of cases, within three to five hours after the use of morphin and magnesium sulphate, the patients had marked relief. In a few cases it was necessary to repeat the morphin. When the patients were discharged all symptoms had disappeared except in eight, who had slight tingling and ache in the lower extremities, which persisted from one to seven days. There were no fatalities and no seriously ill cases.

COMMENT

It is believed that the venom or toxin injected by the black widow spider travels very rapidly, and the acuteness of the case depends upon the amount and area injected. It is felt that the spider does not inject a sufficient amount at one time to cause a fatality. Acute symptoms set in within one-half to two hours after biting, and the effects appear self-limiting, the duration depending upon the amount of toxic material injected. The toxic effect of the bite can be controlled by medication as outlined. Thirty to forty hours should be sufficient to overcome the effects of the bite. The systemic reaction is not so marked as previously thought.

IN CONCLUSION

1. Forty-four additional cases of black widow spider bite are described.
2. No fatalities were noted in ninety-six cases.
3. Symptoms appear to be constant, depending upon region bitten.
4. Treatment, as previously and here outlined, proved very successful.

The General Hospital of Fresno County.

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DISCUSSION

WILLIAM J. KERR, M.D. (University of California Medical School, San Francisco).—Doctor Ginsburg has had an unusual experience in the diagnosis and treatment of black widow spider bite, or arachnoidism. Very few of us who live in urban districts have an opportunity to study such patients because the family physician in the rural districts is the one who sees them during the acute stages, and particularly during the period when they have severe aches, abdominal cramps and other abdominal symptoms.

It has been of especial interest to me to learn how widespread the habitat of these spiders is in this country and in other parts of the world, and to be able to emphasize to medical students the importance of considering the bite of this spider in the differential diagnosis of abdominal crises. Although most individuals know that they have been bitten, there are some instances where there is no clear-cut history of a bite. From all I can learn, those who have been bitten previously may have bites on subsequent occasions without developing serious symptoms.

Once the diagnosis is established, the important thing is the relief of the symptoms, which may be obtained by the measures suggested by Doctor Ginsburg. However, other drugs may be used with benefit. Calcium chlorid given intravenously in doses of 0.5 gram or more may be of benefit in relieving the symptoms, as has been recently reported. Also convalescent serum has been reported of value in relieving the symptoms. In some of the larger

hospitals in rural districts, it may be advisable to keep such antisera on hand for control of the serious acute symptoms. It is possible that individuals may be vaccinated against the toxic effects of the bite of this spider by being given increasing doses of the toxic material. This, of course, would be of importance only in highly infested regions. A low mortality from the bite of this spider is quite universal. I understand that natural parasites are being sought which will destroy the eggs of the black widow spider, and if such measures are found effective, we may be able to eradicate this pest from our gardens and privies.

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EMIL BOGEN, M. D. (Olive View).—The forty-four additional cases of spider-bite poisoning reported by Doctor Ginsburg emphasize the increasing frequency of recognition of this condition. Since this spider has been seen in all parts of the United States and Canada, except Alaska, Vermont, Connecticut, Rhode Island, New Jersey and Delaware, and serious poisoning from its bite has been reported from more than half of the states of the Union, this can no longer be considered a California problem alone, although California physicians appear to have been more alert in its recognition.

The mode of spread of the local symptoms, as described by the author in agreement with earlier descriptions, suggests rapid passage through the central nervous system, with symptoms arising as it reaches the spinal cord, particularly the motor cells, rather than the generally assumed lymphatic absorption with effect on the myoneural junctions.

In differential diagnosis, the history of a bite, or of seeing the spider, although helpful, is not essential, either in making or in excluding the diagnosis, nor should the presence of an ulcer history, or the possibility of eliciting other complaints by leading questions, exclude the possibility of coincident arachnoidism. Collapse with subnormal temperature, as developed by Blair following an experimental spider bite, is rare, but increased blood pressure and spinal fluid pressure are commonly observed.

The author is to be congratulated on the simple, safe, and successful treatment used. The intravenous or intramuscular injection of 10 cubic centimeters of 10 per cent calcium gluconate, as described by Gilbert and Stewart and confirmed by others, seems to be even more effective than the magnesium sulphate. Spinal puncture, or a simple hot tub bath, may also give marked symptomatic relief. In view of the excellent results reported with these simple measures, the use of convalescent human serum, or the even more potent animal antisera now commercially available are, perhaps, mainly of academic interest. Since many of the reported fatalities resulted from secondary infection of the site of the bite, the use of any simple local antiseptic, and avoidance of the useless trauma of incision, cauterization or suction, may be worth remembering.

CANCER OF THE KIDNEY*

PRESENT-DAY STATUS OF ITS TREATMENT,
AND END-RESULTS

By CHARLES PIERRE MATHÉ, M.D.
San Francisco

DISCUSSION by Lionel P. Player, M.D., San Francisco;
J. A. Dougherty, M.D., Oakland; Wirt B. Dakin, M.D.,
Los Angeles.

WHILE serving on the section for study of genito-urinary tumors, recently created by the Cancer Commission of the California Medical Association, I was impressed by the diversity of the present-day methods of attacking cancer of the kidney. From the replies to a questionnaire,

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Fig. 1a

Fig. 1b

Fig. 1c

Fig. 1a.—Right pyelogram of male patient, age 46, suffering from pain and hematuria of four days' duration. Note filling defect of lower major calyx. Defects so slight and symptoms of such short duration that recheck pyelogram was decided upon before intervening.

Fig. 1b.—Pyelogram made six weeks later, showing increase in size of filling defect due to growth of tumor.

Fig. 1c.—Sagittal section of kidney removed by operation, presenting very early cortical tumor of lower pole. The patient is living and well two and a half years after nephrectomy.

we found that practically all urologists favored nephrectomy, which had given them the greatest number of five-year cures, while they reserve radiation for postoperative treatment and for palliative treatment of inoperable tumors. However, the radiologists also desire *preoperative* radiation, pointing out the fact that it causes regression of huge growths, thereby rendering certain inoperable tumors operable, and also lessens metastasis and diminishes hemorrhage.

And so, with the object of improving the end-results obtained in treating cancer of the kidney, which are generally acknowledged to be quite poor, I made a review of thirty-five cases of kidney tumors that were treated in the urologic service of St. Mary's Hospital and the Southern Pacific General Hospital during the past twenty years. The fact that 44 per cent of our patients were restored to health and are living as long as fourteen years after operative removal, with and without radiation, acted as a stimulus for early detection of renal tumor, at which time surgical removal can be favorably employed and is more likely to be followed by success.

Hematuria was found to be the most outstanding symptom, occurring in 62.8 per cent of our cases. When hematuria occurs in conjunction with pain and tumefaction of the kidney, accompanied by other urinary symptoms, one's attention should be directed to the kidney with the object of searching for renal tumor. The earlier the diagnosis the more likelihood there is of effecting a cure, and yet cancer of the kidney is so insidious in its early clinical manifestations that one is unlikely to detect it during its early stages. We encountered three very early cases, all of which were relieved and are living fourteen, seven, and three years after nephrectomy. Therefore, we advise that physicians be cancer-minded when investigating and attempting to make a differential diagnosis of patients suffering from hematuria.

EARLY DIAGNOSIS OF RENAL TUMORS

The early diagnosis of malignant tumors of the kidney is quite difficult. In the past a goodly number were recognized on the autopsy or in the last stages when large swelling had developed and extensive metastasis had taken place. Two of our cases were diagnosed on the autopsy table, and these had presented vague symptoms during life. Two others were encountered when operating on the kidney for another condition, hypernephroma of adrenal body, encountered while removing a calculous pyonephrosis; sarcoma of the upper pole while operating on hydronephrosis, secondary to ptosis. We also treated four advanced patients with metastases in the lungs, pelvis, and long bones, which were in a stage far beyond surgical aid. These often presented a history of symptoms dating back over a long period of time. A proper diagnosis could have been made at the onset of symptoms if the possibility of renal tumor had occurred to the attending physician, and if a complete urologic investigation had been made.

Hematuria.—Hematuria is the most constant and outstanding symptom. Whether it is slight or extensive, transient or persistent, it calls for a complete examination of the kidneys before assuming that bleeding is harmless. Pain and tumefaction aid in confirming the diagnosis. In cases in which the tumor is located in the cortex of the kidney, hematuria does not occur, at least until invasion of the pelvis has taken place. We observed a sudden swelling in the left upper abdomen and loin in a patient on whom neoplasm of the left kidney had been previously diagnosed by urologic investigation. Operation was refused and the patient rapidly went into collapse and died. Autopsy revealed spontaneous rupture of the kidney, with extensive extravasation of blood in the retroperitoneal space. Crane reported a similar case, presenting no previous urinary signs nor symptoms. A large tumor mass suddenly de-



Fig. 2a.

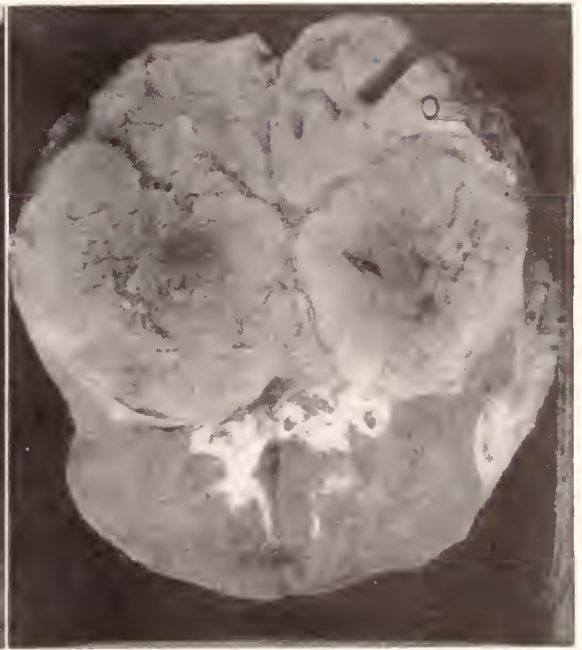


Fig. 2b

Fig. 2a.—Left pyelogram of female, age 36, presenting hematuria, pain, and tumefaction. Note elongation and enlargement of upper major calyx, with extension of the opaque media into adjacent cortex.

Fig. 2b.—Sagittal section of kidney removed by operation, showing large hypernephroma of the upper pole presenting necrosis in its center.

veloped in the right upper abdomen, and at operation this was found to be due to extensive subcapsular hemorrhage from a cortical tumor. Some patients present symptoms due to obstruction of the urinary outflow; others have gastro-intestinal symptoms, pain in the abdomen, weakness, loss of weight, cachexia, etc., with no actual symptoms pointing to the kidney. In all these obscure cases one should bear the kidney in mind, and should make a complete urologic examination, including intravenous and retrograde pyelography, with the object of detecting renal tumor. Unfortunately, when the classical triad of cardinal symptoms, consisting of hematuria, pain, and tumefaction, do occur, the tumor has often metastasized and is beyond surgical relief.

Retrograde Pyelography.—In the diagnosis of early renal tumor, retrograde pyelography should be employed. Although excretory urography aids in localizing the tumor in the kidney, it is of decisive value only in fairly well-advanced cases. In patients presenting early small tumors it is inaccurate and often leads to erroneous conclusions, and therefore cannot be depended upon. In cortical tumors, hypernephroma, embryoma, sarcoma, etc., the elongation, displacement, filling defect, or occlusion of one or two calices due to compression, and obtained in making the pyelogram, are quite characteristic. With its growth the tumor may compress the pelvis, resulting in a so-called spider- or dragon-shaped distortion. In advanced cases the tumor can almost entirely obliterate the pelvis. Secondary necrosis simulates the impression of abscess formation. However, these phenomena can be produced by fibrolipomatosis of the perirenal tissues, congenital anomalies, cyst, carbuncle,

abscess formation, or tuberculosis, and confused with neoplasm of the kidney. In renal carbuncle, cortical abscess of the kidney, and tuberculosis, the kidney is fixed and this lack of renal mobility is demonstrated in taking the pyelogram in the vertical position. We recently emphasized this important sign as a diagnostic point in distinguishing these inflammatory conditions from other lesions of the kidney, such as renal tumor, in which the kidney usually retains its normal mobility. Tumors of the pelvis present the characteristic filling defect and a moth-eaten appearance of the pelvic outline. Rarely filling defects in the pelvis are also caused by a blood-clot or large air bubbles.

The characteristic x-ray findings of cortical and pelvic tumors have been repeatedly described and are now recognized by all competent urologists. However, the diagnosis of early tumors requires intelligent interpretation of the patient's history and careful analysis of the clinical findings. In case of doubt the pyelogram should be repeated, and if positive findings are still found to be present, exploratory operation should be performed. Four patients were operated for renal tumor in whom none was encountered:

In one the pyelographic changes were due to perirenal fibrolipomatosis, involving the pelvis; in another they were produced by congenital deformity; in the third they were caused by arteriosclerotic changes localized in the upper pole of the kidney, and in the fourth the filling defect was found to have been due to a huge blood-clot. An extremely early case of adenocarcinoma of the lower pole of the kidney was recently diagnosed and relieved by operation. The patient presented hematuria of four days' duration, and in making the pyelogram a small filling defect was noted in the lower major calyx by Dr. Lloyd Crow, roentgenologist of the Southern Pacific General Hospital. The defect was so slight, and the patient's symptoms of such short duration, that we decided to wait and repeat



Fig. 3.—Sagittal section of kidney, presenting adeno-papilloma of pelvis removed from male, age 59, presenting hematuria, pain, and frequency. The pelvic type of tumor is radio-resistant and highly malignant. The patient died of metastasis seven months after operation.

the pyelogram before intervening. A month later a recheck pyelogram revealed that the growth had slightly increased in size. The kidney was, therefore, removed and an adenocarcinoma about 1.5 centimeters in diameter was found in the lower pole of the kidney. As far as I know, this is the earliest case of primar carcinoma of the kidney ever diagnosed prior to operation, and the patient is well and free of symptoms two years after operation.

TREATMENT

In spite of the advances and improvements of technique in radiation therapy, early nephrectomy remains the treatment of choice for malignant tumor of the kidney. Heminephrectomy is indicated in cases of tumor limited to one portion of a bifid kidney, and partial resection can be carried out in cases in which cysts, benign tumors, or well-encapsulated malignant tumors are encountered. We successfully carried out heminephrectomy and partial resection in two cases of malignant tumor. One was limited to the upper half of a bifid kidney, whereas the other was well encapsulated. Preoperative irradiation has been recently advocated by Waters, and has been adopted by many roentgenologists. In 1904, Berjonié and Tribondeau observed the selective action of the roentgen ray in rats, pointing out that immature cells and those in an active state of division are more sensitive to radiation than are cells which have already acquired their adult morphologic and physiologic characteristics. Roentgenologists soon utilized this principle in applying radiation therapy to malignant growths in the body, including the kidney. It has been observed that cortical tumors, comprising hypernephromata and embryomata, are quite radiosensitive, whereas pelvic tumors, consisting of malignant papillary carcinoma, are radio-resistant. Therefore, it is important to identify the type of tumor before instituting preoperative radiation, and this can be ascertained by carefully studying the pyelogram. One should not lose time

TABLE 1.—Classification of Renal Tumors		
Cortical	Adenocarcinoma	10
	Hypernephroma	4
	Angiosarcoma	1
	Sarcoma	1
	Teratoma and cyst	1
	Adeno-myo-chondro-osteomyoma	1
	Adeno-chondro-osteoma	1
	Solitary cyst	1
	Adenopapilloma	10
	Perirenal	
Pelvic	Lymphoblastoma	1
	Fibrolipomatosis	1
Suprarenal	Hypernephroma	2
	Benign cyst	1
Total		35

in employing preoperative radiation in the tumors of the renal pelvis, as these are radio-resistant. Before 1935 radiation of kidney tumors was limited to inoperable advanced growths, usually presenting extensive metastasis. In 1927 we were impressed by the marked regression of a huge inoperable perirenal lymphoblastoma, which was achieved by radiation. We reported the case at the 1926 meeting of the Western Branch of the American Urological Association. The patient died of metastasis, but the original extensive growth was reduced to such an extent that it led us to believe that this phenomena might be utilized in rendering inoperable growths operable. Waters, however, was the first to actually use preoperative radiation for this purpose. This principle has since been adopted by many roentgenologists and urologists. Radiation not only causes marked regression in the size of the tumor, but controls hemorrhage and also minimizes metastasis without producing any lasting damage to the remaining healthy kidney. Regression by radiation is brought about by stimulating the normal tissue defense against cancer, which is due to changing the balance between stroma and parenchyma of a given tumor. Postoperative radiation is also used for the purpose of devitalizing any cancerous cells that might have been left behind at the time of operation, thus preventing metastasis as well as recurrence of the growth in the wound. We feel that radiation will never supplant surgical removal nor will it render operative interference unnecessary.

TECHNICAL POINTS NECESSARY FOR
SUCCESSFUL REMOVAL

We wish to emphasize certain technical points which should be carried out in performing nephrectomy. These aid in the prevention of the spread of cancerous cells into the blood stream, thereby minimizing the risk of metastasis. The renal pedicle should be clamped early in order that manipulation necessary to deliver and free the

TABLE 2.—Analysis of Cases	
Cases submitted to surgical removal	27
Cases found inoperable	2
Cases discovered at autopsy	2
Advanced cases with metastasis	4
Total	35

TABLE 3.—Types of Operation

Nephrectomy	22
Ureteronephrectomy	2
Heminephrectomy	1
Partial resection	1
Resection adrenal cyst	1
	27
Operative mortality—11.11%.	
Ureterectomy for papilloma left after nephrectomy	1
Ureteronephrectomy for primary carcinoma ureter	1

kidney will not introduce cancerous cells into the blood stream. In attacking tumors of considerable size, one can employ the abdominal route in order to obtain easier access to the pedicle. Nephrectomy by the abdominal route, however, has a higher mortality, is more likely to be followed by peritonitis, obstruction of the intestines, etc., and does not have to be employed, as one can extend the numerous types of retroperitoneal incisions now at our command to such an extent as to provide sufficient exposure for access to the pedicle. In cases of papillary carcinoma of the pelvis, in which involvement of the ureter is encountered, a complete nephro-ureterectomy should be performed. The kidney is removed through the lumbar incision, after which the usual abdominal retroperitoneal curvilinear incision for exposure and removal of the lower ureter is carried out. Some surgeons advise the use of the cutting current in order to seal the blood vessels as the tissues are incised. Alcohol sponges are used in order to destroy any cancerous cells that might have been liberated in the wound. In the surgical attack of renal cancer, success depends upon reasonable operative skill, minimum trauma, gentle manipulation, early ligation of the pedicle and sufficient exposure to facilitate the operation, and in this field there is no place for the tearing, prying, delving, and hard-retracting surgeon.

ANALYSIS OF CASES

Of the thirty-six cases in this series, twenty-four were treated by nephrectomy, and three by resection of the tumor mass (encapsulated sarcoma, adrenal cyst, and hypernephroma of the suprarenal gland). Of the remaining nine cases, two were discovered on the autopsy table, three proved to be inoperable at the time of operation, and four were found to be far advanced with numerous metastases. Postoperative radiation, consisting of radium and deep x-ray therapy, was utilized in a large number of cases in which nephrectomy was performed. Preoperative radiation is

TABLE 4.—Results

Nephrectomy	(24)—10 cases living (8 five-year cures)
Resection	(2)— 2 cases living
Heminephrectomy	(1)— 1 case living
Total	27 13 cases living 14 dead (44% relieved)
Preoperative radiation	(2)—2 cases dead
Palliative radiation	(6)—None living—all 6 dead
Postoperative radiation	(12)—7 cases living



Fig. 4.—Specimen, consisting of huge papillary adenocarcinoma of the renal pelvis, removed from male, age 46. The patient succumbed from shock during operation. Preoperative radiation reduces the size of this type of cancer

employed in the treatment of exceedingly large growths, in which regression of the tumor is desired in order to make possible radical removal. In small growths we do not employ it, as we do not wish to lose any time and prefer to operate immediately before metastasis will have a chance to set in. Our operative mortality for nephrectomy for renal cancer was 11.11 per cent (three in twenty-seven operations). One patient died on the table. He presented an extremely large pelvic tumor of the right kidney, with numerous large capsular blood vessels; and just as we exerted traction on the kidney in order to ligate the pedicle and to extirpate the kidney the patient went into shock and rapidly succumbed. The second patient died of pulmonary embolus two days after nephrectomy, and the third died five days later because of cardiac collapse.

OPERATIVE MORTALITY

In reviewing statistics on nephrectomy we find that the operative mortality is far higher than that performed for other lesions of the kidney. To name a few: Squier (1909) 50 per cent; Braasch (1913) 11 per cent; Hyman (1920) 23 to 37 per cent. Its present-day mean mortality is about 19 per cent. The reasons for the unusually high mortality for nephrectomy for tumor are: shock resulting from the manipulation necessary for the removal of large tumors, hemorrhage, the formation of thrombi due to cancerous cells breaking off and entering the circulation by way of the renal vein, and cardiac failure due to toxemia. Death from cardiac failure following nephrectomy has been explained by the fact that toxins, formed

by the cancerous cells which have entered the circulation by way of the renal vein, cause toxic myocarditis, resulting in a fatal issue. Generally speaking, tumors presenting huge dimensions, and those offering technical difficulties in their removal, have a higher mortality and a poorer prognosis. Tumors that have ruptured through the capsule or the pelvis, and those that have involved the peritoneum and renal vessels, present a higher mortality and poorer prognosis. This is not always true, as two of our patients presenting huge adenocarcinomata of the kidney cortex in which the removal was exceedingly difficult, are living seven and five years after operation; whereas others, operated for small growths involving the pelvis, soon developed metastases, rapidly became cachexic and died five to seven months following operation. Of interest was a patient, referred by Dr. G. Milani, presenting a huge adenopapilloma of the renal pelvis, with direct extension into the renal vein. We were forced to incise the vena cava in order to resect the renal vein which had been invaded by the tumor. The patient went into collapse on the table, but was resuscitated with the administration of intravenous glucose and of cardiac stimulants. He made an uneventful recovery, is now living and is in excellent health some five years after operation! Two other patients presenting huge adenocarcinoma of the pelvis, in whom removal of the kidney was very difficult, are living eight and two years after operation. It is a question if preoperative radiation would have assisted in making the operation easier in these patients, as they presented radio-resistant pelvic tumors. In contradistinction to the high operative mortality that we experienced in connection with nephrectomy for renal tumor (13.04 per cent), we noted that extirpation of the kidney for tuberculosis, calculous pyonephrosis, hydronephrosis, etc., was followed by a mortality of less than 2.5 per cent!

RESULTS

It is generally conceded that the results obtained by the treatment of cancer of the kidney are rather poor, yet an analysis of those obtained in our patients in which operation was possible were found to be quite satisfactory. Nephrectomy was performed on twenty-four patients, ten of whom are living and well 14, 12, 11, 8, 7, 6, 5, 3, and 2 years after operation (eight five-year cures). Three patients were relieved by less radical operations, viz., heminephrectomy (one), partial resection (one), and resection of an adrenal cyst (one). One patient developed metastasis shortly after removal of an advanced pelvic adenocarcinoma, is still in the hospital, is rapidly going down hill, and is now in the last stages of cachexia. Three died as a result of the operation, and seven died at intervals of time, varying from three months to one and a half years after operation. Two patients were lost sight of. The fact that thirteen of the twenty-seven patients operated upon (44 per cent) are living and well after operative intervention clearly demonstrates that surgical removal is well worth while, is the treatment of choice and should act as a stimulus for the early

detection of renal tumor, at which time operation is more likely to be followed by a cure. In this group were three exceedingly early cancers, two of which were encountered in the course of operating on the kidney for other lesions, whereas the third was diagnosed four days after the onset of the patient's first and only attack of hematuria. Of interest was a patient presenting a very early tumor of the upper pole, diagnosed by pyelography, in which elongation of the upper major calyx was encountered. Exploratory operation was refused, however; her symptoms became worse and six months later, at the San Francisco Hospital, Doctor Sullivan removed the left kidney, containing a fairly well-advanced carcinoma of the organ.

SUMMARY

1. An analysis of a study recently made by the Cancer Commission of the California Medical Association and of our end-results obtained in the treatment of thirty-six cases of cancer of the kidney led us to believe that nephrectomy is still the treatment of choice.

2. Radiation is of value, but should not supplant surgical removal. Preoperative radiation is of value in producing regression of huge growths, thereby rendering certain inoperable tumors operable. Postoperative radiation is employed in order to lessen the risk of metastasis. Radiation for the treatment of inoperable tumors, although of some palliative value, has not effected permanent relief.

3. Hematuria is the most constant and outstanding symptom, and the attending physician should bear cancer of the kidney in mind when investigating or attempting to make a differential diagnosis of patients suffering from hematuria.

4. The earlier the diagnosis the more likelihood of effecting a clinical cure, yet the early manifestations of renal tumor are so insidious that one is likely to overlook them in the early stages. In doubtful cases, one should repeat the pyelographic studies and the surgeon is justified in making an exploratory operation.

5. Success following surgical excision depends on the employment of certain technical surgical points, consisting of early ligation of the renal pedicle, sufficient exposure, minimum trauma, gentle manipulation, postoperative radiation, etc.

6. Ten of the twenty-four patients treated by nephrectomy (twelve of which also had postoperative radiation) are living and well from fourteen to two years after operation (eight five-year cures); three patients were relieved by partial resection; thirteen of the twenty-seven patients operated upon (44 per cent) apparently have been relieved, 33⅓ per cent of which are five-year cures, demonstrating that surgical removal, supplemented by radiation, is the treatment of choice and is more likely to be followed by a cure.

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DISCUSSION

LIONEL P. PLAYER, M. D. (384 Post Street, San Francisco).—The essayist aptly emphasizes important facts concerning the diagnosis, symptoms, preoperative and surgical treatment of renal tumors. When sifted down to

bare facts the earliest symptom in the great majority of cases of renal tumor is hematuria, which may be so slight as to go unnoticed by the patient.

Roentgenograms showing pressure or filling defects are the next early signs. Pain and tumor are late manifestations of renal cancer. Red blood cells in the voided urine, unless the source is ascertained otherwise, demand a full cystoscopic, laboratory and roentgenologic study, as it is only by careful correlation of all findings that an early diagnosis of renal tumors can be established. Pyelograms in renal tuberculosis may simulate cancer of the renal pelvis, and for this reason guinea-pig inoculation and frequent acid-fast stains of the catheterized urine are indicated.

Judging from the statistics available at the moment, success in the surgical handling of these cases is in direct proportion to the early recognition of tumor.

The results in Doctor Mathé's collection of cases are strikingly gratifying; the number of patients living after the accepted period of from three to five years being particularly great when compared with the general average contained in other statistical reports.

Surgery alone, or in combination with diathermy, radium, x-ray, fulguration, etc., excepting in very early cases of cancer, is in general most disappointing, and the mortality rate, as a rule, has not changed materially in the last ten years.

The more or less recent studies of Kolisher, Horn, Goldschmidt, Landau, Aschoff, Kitasato, and others, conducted on animals previously inoculated with cancer, offer a new angle for constitutional treatment of cancer. They have demonstrated, in the reticulo-endothelial system, macrophages which possess migratory properties and are attracted to points in the body where there is an unbalance in metabolism; thus, they are attracted to the site of the tumor when agents such as radium, x-ray, etc., are employed for the destruction of these neoplasms. From these reports one is led to believe that what has been termed sensitivity to radium in reality does not exist; the effect on the tumor is dependent upon the specific action of the macrophage is effective only when taken from and presence of radium causes an unbalanced metabolism.

Injectations of macrophage emulsion into and around the tumor in experimental animals caused the disappearance of or diminution in the size of the tumors. In other instances the cancer cells have been inactivated. The action of the macrophages is effective only when taken from and employed in like species.

Scientists engaged in research in this new field of therapy are endeavoring to produce a macrophage emulsion from the spleen and other tissues of the reticulo-endothelial system which, in itself or associated with surgery, promises new hope in the eradication of cancer.

✽

J. A. DOUGHERTY, M. D. (3115 Webster Street, Oakland).—In a consideration of renal malignancies there are three points which force themselves upon our attention. First: In the early signs and symptoms there is no one sign post which points indisputably to renal cancer, or which might not be caused by some other renal lesion, or otherwise. Second: The kidney does not lend itself kindly to exploration, and in most cases these investigations end in nephrectomy. Third: When the diagnosis is clearly evident it is oftentimes too late for effective surgery.

For the purpose of early diagnosis it would be better if the triad of hematuria, pain, and tumor were forgotten and the medical profession impress it upon themselves and their patients that the presence of blood in the urine is a sign of the gravest import, which merits the most painstaking investigation. In this connection it must not be forgotten that in the mixed tumor of childhood the above signs are in reverse order and that a palpable tumor and pain may exist for an indefinite period without hematuria. I have recently seen a three-year-old boy, whose right abdomen was occupied by a Wilms tumor, in whom repeated urine examinations showed no red blood cells.

Among the conditions which may make the diagnosis of renal tumor difficult, those deformities produced by

blood-clots within the pelvis have given me most trouble. It is sometimes necessary to repeat the pyelograms within a few weeks to differentiate between tumor and blood-clot. To explain this program to a patient who has just gone through the discomfort and expense of a cystoscopic seance may tax the resources of the most seasoned diplomat.

Doctor Mathé's consideration of treatment leaves little to discuss. In my brief experience preoperative radiation has been most effective in tumors of the Wilms type. I must confess that I have never used radiation preoperatively in tumors of the renal pelvis. Doctor Mathé has advised the removal of the ureter in pelvic tumors, and I would like to add my emphasis. These tumors commonly invade the bladder via the ureter, and to leave the ureter behind is to court disaster. Likewise, when there are transplants in or around the ureteral orifice it is necessary to excise the tumor-bearing area of the bladder.

I have recently reviewed the histories of forty-nine renal neoplasms. Of this group 18.9 per cent are symptom-free on an average of 3.5 years; 45.8 per cent are recurrent on an average of 20.5 months; and 35.4 per cent are dead on an average of 12.3 months, postoperative. In this group the preoperative duration of symptoms was sixteen months. In a smaller series, where the preoperative duration of symptoms was 6.8 days, the recurrence was 50 per cent.

While this comparison may strike a pessimistic note, it is at least a small step in the right direction. Probably the adoption of such steps as outlined by Doctor Mathé will further this difference.

✽

WIRT B. DAKIN, M. D. (802 Pacific Mutual Building, Los Angeles).—Doctor Mathé has given us an interesting study in this review of all the cases of cancer of the kidney that have been operated in two of the leading hospitals of the Pacific Coast.

During the last few years the highly commendable endeavors of various commissions for the study of cancer throughout the country have been most helpful in giving medical men a summary of general opinion which enables them better to manage this serious disease. Different commissions have concentrated their efforts on the study of cancer in various parts of the body, but none have obtained better results than the urologists. Although men holding teaching positions are surrounded by better facilities to give more voluminous reports than some of their fellow practitioners, this should not discourage the man with the occasional case report from contributing his share to the general body of knowledge on the subject. Until we have evolved a treatment such as we now have for most cases of malaria, diphtheria, and syphilis, for example—until the time arrives when we know definitely the cause of cancer, the best we can do is to study and make use of the knowledge gained by these recent investigations.

At best, cancer of the kidney can never be detected as early as similar conditions of the skin and some other organs of the body. However, quicker diagnoses would result in many cases if the physician would immediately investigate every case of blood in the urine. Hematuria is the earliest, most frequent, and often the only symptom. By the time the pain and tumor mass develop, the condition is far advanced.

In the diagnostic examination a careful history and general examination should always precede the routine urologic investigation. This will give a clue to the real condition present. The blood picture, asthenia, loss of weight, or general appearance of carcinoma, will suggest a malignancy somewhere in the body. Intravenous pyelography should never be anything but a corroborative procedure. Urologists always make retrograde pyelograms in cases of suspected kidney cancer, unless there is a serious contraindication to cystoscopy. Blood-clots, air-bubbles, etc., which might give us an erroneous opinion concerning pyelograms, are a rare occurrence; even when present, they never yield the typical "spider"- or "dragon-shaped" pyelogram of kidney cancer. . . .

BROMID INTOXICATION*

By G. CRESWELL BURNS, M.D.

AND

J. L. HENDERSON, M.D.

Compton

DISCUSSION by Clinton H. Thienes, M.D., Los Angeles; Edward W. Twitchell, M.D., San Francisco; George S. Johnson, M.D., San Francisco.

SEVERAL writers in the past quarter of a century have pointed out that the injudicious use of bromids may produce a toxic psychosis.¹⁻²⁴ Our observations indicate that the general practitioner, puzzled by the alarming mental symptoms that develop, may even unwittingly prescribe larger doses of the drug in an effort to quiet his delirious patient. That we have seen twenty-one such patients in the past year and a half seems sufficient reason for feeling that this condition requires more emphasis.

Twenty-six years have elapsed since Ulrich²⁵ discovered a method of determining the bromid content of the blood. Long before 1910, clinicians recognized that the continued use of bromids not infrequently produced mental symptoms.^{1,2} Walter²⁵ in 1912 published a simpler procedure than Ulrich's for determining quantitatively the amount of bromid in the blood, and this procedure, with modifications, was principally in use until 1927, when Wuth devised his comparator. Since then probably Wuth's method has been more widely employed.³

It was not until after Wuth's article, with a report of nine cases, that papers on the subject began to appear with any degree of regularity. Wagner and Bunbury,¹⁰ soon after Diethelm's work was published, reported on their investigation of one thousand consecutive admissions to the University of Colorado Psychopathic Hospital, in which they found that 7.7 per cent of those patients studied showed bromid in the blood of 75 milligrams per 100 cubic centimeters and over. Forty-four, or 4.4 per cent of the total number, had mental symptoms due to or increased by the bromid.

PHARMACOLOGY

The chlorid content of the body is automatically maintained at a remarkably constant level.^{26, 27, 28} When excess chlorid is ingested an excess is excreted. When the amount ingested is reduced to a minimum, the amount excreted is likewise reduced.²⁶ When bromid or iodid is ingested, a comparable amount of chlorid is excreted, indicating that the chlorid has been replaced.²⁷ If no further bromid is ingested, the amount already in the body is excreted slowly in diminishing amounts (assuming a small constant chlorid intake) for weeks or months.²⁶ If, however, more bromid is daily ingested, further chlorid is excreted and further replacement occurs until there is sufficient accumulation to produce clinical effects.

The bromid ion at first is distributed in such a manner that its concentration is greater in the

cells than in the plasma.^{28, 29} Mason³³ found this condition is maintained throughout the period of intoxication, while Palmer and Clarke²⁶ reported that a balance is soon reached when the cell walls do not differentiate between chlorid and bromid ions.

The degree to which, and the rapidity with which, bromid replaces chlorid are dependent on the ratio between ingested bromid and chlorid.³⁴ A most striking example of the correlation between the replacement by bromid and the ratio of the bromid-chlorid intake has been reported by Harding and Harding.¹⁸ A patient with epilepsy over a period of twelve years took a certain daily dose of bromid which kept in abeyance his major seizures. He then visited his sister, who used no salt in her cooking, and with the same daily bromid intake developed symptoms of a bromid delirium, necessitating hospitalization.

The amount of bromid accumulation necessary for the production of clinical symptoms varies to an astonishing degree. Among the factors mentioned in the literature predisposing to bromid accumulation are found: age, arteriosclerosis, syphilis, alcoholism, nephritis, dehydration, cachexia, and anemia. Most of these appear to be causative on the basis of impaired renal elimination. A few of these factors probably have already impaired the central nervous system, leaving it more susceptible to any toxin. Then, too, each person has a threshold which, with all the foregoing factors eliminated, is extremely variable,³⁴ just as there are individual variations in the susceptibility to alcoholic intoxication³¹ or to convulsive disorders. Thus, Katzenelbogen, Goldsmith, and White¹⁷ cited two cases in which symptoms appeared at the neurologic level with blood bromid concentrations of 120 and 147 per 100 cubic centimeters, and two other cases in which there were no demonstrable clinical manifestations with blood bromid values of 315 and 385 milligrams per 100 cubic centimeters. Sippe and Bostock¹² produced blood bromid concentrations of 350 and 375 milligrams per 100 cubic centimeters, with drowsiness as the only symptom, and at the same time reported six cases of bromid intoxication with blood bromid values ranging from 200 to 275 milligrams per 100 cubic centimeters.

If the ingestion of bromids is stopped, the symptoms of intoxication slowly clear up. This is largely due to the replacement by sodium chlorid in the ordinary diet, which daily amount of salt has been estimated to be 10 to 20 grams. Wuth³ found the ordinary hospital diet had a daily sodium chlorid value of 2.68 to 15.84 grams, with an average of 7.4 grams. If this supply of table salt is supplemented by additional chlorid, the bromid is displaced and excreted proportionately faster.

It has been shown that the production of diuresis by means of urea does not increase the excretion of bromid (or halid).²⁶ Nevertheless, excretion of large amounts of either chlorid or bromid always carries along with them proportionally large amounts of water. Therefore, there is need for a large fluid intake. The daily amount

* Read before the General Medicine Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

of sodium chlorid given therapeutically, as indicated in the literature, varies from 2 to 25 grams, in addition to that in the ordinary diet. These authors correctly emphasize that with the higher doses a large fluid intake be maintained.

It has been shown experimentally that the replacement of chlorid by bromid in the cell so shifts the Donnan membrane equilibrium that water migrates to the plasma. If this condition is maintained over a period of time necessary to produce a bromid intoxication, this shift in water balance would largely explain the dehydration almost always observed as a part of the clinical picture.

SYMPTOMATOLOGY

The clinical effects of bromid appear slowly because their production is dependent on accumulation. The first effect is that of drowsiness and diminution of sensory perception. The latter accounts for the early abolition of pharyngeal, abdominal and corneal reflexes.¹⁷ Next appears a picture of intoxication with headache, weakness, irritability, anorexia, thick, hesitant speech, uncertain gait, generalized coarse tremors, and vacuous facies. The pupils are frequently sluggish in response to light, and occasionally unequal. Dizziness, diplopia, and blurring of vision are fairly common. These symptoms are expressed principally at the neurologic level, and the syndrome is not unlike that of alcoholic intoxication.

As the bromids accumulate there is superimposed, usually suddenly, an acute delirium characterized by confusion, disorientation, memory defect and vivid hallucinations of any type, but principally of sight and sound, to which there is an acute reaction of fear or horror. The patient is acutely disturbed and noisy, making attempts to fight or escape. This second group of symptoms is expressed at the psychologic level and is not unlike delirium tremens.

With further bromid accumulation, stupor is superimposed. The skin is muddy, the breath foul, and the tongue heavily furred. Dehydration is almost always present. There is frequently difficulty in swallowing, and tube feeding is often necessary. Usually there is a breaking through of the delirium with noisy intervals. Only occasionally are there skin manifestations.

The blood bromid concentration responsible for these symptoms is indefinite because of the many factors influencing susceptibility. Harding and Harding¹⁸ have stated that in general no symptoms appear when the blood bromid concentration is under 100 milligrams per 100 cubic centimeters. Between 100 and 150 milligrams per 100 cubic centimeters there occurs a depressed stage. Above 300 milligrams per 100 cubic centimeters, stupor usually occurs. However, it must be remembered that blood bromid concentrations well over 300 milligrams per 100 cubic centimeters have frequently been seen without producing symptoms other than drowsiness.

The delirium usually clears with striking suddenness, generally in the morning. Occasionally the patient remains clear, but more often there is a recurrence of the confusion in the afternoon or

evening for a few days. At times hallucinations recur with the confusion, but more often there are complaints of terrifying dreams at night.

The time required for the clearing up of the symptoms is directly proportional to the amount of bromid accumulated and inversely proportional to the amount of chlorid and fluid given,¹⁶ and the degree of renal impairment if this is present.

REPORT OF CASE

CASE 19.—F. R. R., 41-year-old unmarried woman, assistant in a physician's office, was admitted to the sanitarium on October 23, 1935, because of a confused mental state. An emotional disturbance had led her to take bromids and other sedatives in excess periodically for the past year, but symptoms of intoxication did not become pronounced until five days before admission, when she thought people were bothering her through a radio in her room. She became noisy, thought that a dog and man were after her, and was afraid of being shot. On admission she was suspicious, talkative, and overly active. Her speech was rambling and slurred. There was a papulopustular eruption over her back. Her pupils were widely dilated and equal, reacted well to light, but the reflex was not sustained. There was a fine tremor of her tongue and outstretched hands. Incoördination was marked, the patient being extremely uncertain in her walking. Deep and superficial reflexes were sluggish. Blood bromid the day of admission was 266 milligrams per 100 cubic centimeters. Though oriented on entering the sanitarium, the patient became in the next few days completely out of touch with her surroundings, and the delirium lasted for three weeks. She was tube-fed for the first week, and given eight grams of salt daily while the delirious state continued. Her mind cleared up suddenly on November 12, 1935. She said it all seemed like a terrible nightmare. During her delirium she would hold her breath to the point of becoming cyanotic, and then would cry out that "they" were holding a dog with hydrophobia over her face and letting the dog's saliva run down into her mouth. Later she had the idea that various persons were cut up into small pieces, and she was afraid she had been taken to an island and was to be mutilated. She was discharged on November 24, 1935, one month after admission, recovered from the toxic psychosis. There was still present evidence of a mild depression.

COMMENT

Of our twenty-one patients, seventeen were women and four men. Their ages varied from thirty-two to seventy-eight, with an average of fifty. In nearly all there was an underlying nervous or mental disorder. Six patients suffered from an involutional psychosis; five patients were definitely psychoneurotic; two had symptoms of a reactive depression; two had a manic-depressive psychosis. One patient suffered from general paresis with cerebral arteriosclerosis and hypertension. One patient was a chronic, periodic alcoholic, and had had a recent sunstroke. Another patient was classified simply as being emotionally unstable. One woman developed a bromid psychosis postoperatively. In one other patient there was no apparent underlying emotional disturbance.

It was difficult to determine the amounts of bromid taken by many of the patients. Most of them took the bromid-containing preparation only as prescribed, but three of the sixteen patients receiving bromid on prescription had refills without their physicians' knowledge, or took in addition another preparation of bromid. Three of the twenty-one patients had been using bromids of their own accord. The source of the bromid in two cases was undetermined. The list of incrimi-

nated preparations is long.³² No one in particular is apparently more to be blamed than another. But some preparations have a higher percentage of bromids than others.

Bromids are generally not prescribed to patients unless there is some good reason for doing so. It follows then that, upon recovery from the bromid intoxication, most of these patients still have a neuropsychiatric problem that requires treatment, the same problem that prompted the use of bromids. Occasionally, in patients quite stable emotionally to begin with, no neuropsychiatric problem remains. In this type of patient, once having recovered from the bromid intoxication, he is well. In our experience, however, and in that of other observers there is usually an underlying emotional disorder with which to contend. The manner in which this personality disturbance alters the composite picture produced by bromid intoxication has been commented on by several writers, notably Diethelm⁶ and Levin.¹⁴ In our series of cases, especially in those in which the blood bromid content was well above the toxic threshold, the psychic picture was strikingly uniform, being one of confusion-delirium, which tended to mask the underlying mental illness. But as the delirium abates, these disorders become apparent. Some patients become paranoid in keeping with their schizoid make-up; others do not. Some patients have more vivid hallucinations than others. In some the fear reaction is pronounced, while in others there is less affect displayed. In retrospect, nearly all of our patients looked upon their experience as something dreadful or horrible. Skin manifestations occurred only occasionally.

DIAGNOSIS

The question of diagnosis brings up several points of interest. We feel certain that in the past we have overlooked cases of bromid intoxication, calling them toxic psychoses. The course of these bromid psychoses may be prolonged for weeks, and even months, when no measures are taken to withdraw the drug.²⁴ One of our patients (Case 9) was in a mild delirious state for five months before admission. Clearing up from the delirium, she demonstrated a surprisingly clear sensorium, became interested and alert again though she continued to be mildly neurotic. One patient (Case 15) with general paresis of recent development, occurring late in life, behaved so differently from the usual parietic patient that a further etiologic factor was considered. Another patient (Case 14) was thought to be suffering from general paresis until bromid was found in the blood. Perhaps many cases of so-called post-operative psychosis might well be instances of bromid psychosis. Relatively small amounts of bromids may easily in a short time result in intoxication if insufficient fluids and saline are administered postoperatively. One of our patients (Case 10) with a mild degree of hyperthyroidism was intentionally given bromids some time before she was operated on for a fibroid uterus. The excitement continued after the operation, and additional bromid medication, instead of diminishing

the excitement, precipitated a delirium. One other patient (Case 7) had a postoperative convalescence that extended into weeks, whereas if no bromids had been prescribed following the operation the period of hospitalization would in all probability have been no longer than usual. Occasionally, the added effect of cannabis indica in neurosine may account in part for the vivid hallucinations which occur when the blood bromid is relatively low (Case 17).

The diagnosis is made by finding bromids in the blood in amounts above the toxic level. All our bromid determinations were done according to the method outlined by Wuth.³ We found blood bromid levels ranging from 133 to 410 milligrams per 100 cubic centimeters.

PROGNOSIS

We were usually able to offer a favorable prognosis. In some instances relatives had abandoned hope and were surprised when recovery, which we expected would occur, did take place. The period of delirium in our cases lasted from ten to twenty days. Those patients with renal sclerosis recovered more slowly (Cases 5 and 9). One death occurred due to myocardial failure (Case 4).

TREATMENT

Treatment consists of supplying the patient with plentiful amounts of fluids and giving sodium chlorid. The rationale of this simple procedure is apparent when the biochemistry of the intoxication is understood. In the usual case, six to eight grams of sodium chlorid daily are given. When patients require gavage the salt may be given in the tube feedings. Later, when they are able to eat, salt may be given in capsules. Obviously all bromid medication should be discontinued as soon as the possibility of bromid intoxication is suspected. Other sedatives to allay extreme restlessness and anxiety may be required. Warm continuous baths have a greater sedative effect and favor diaphoresis. These patients need food rich in vitamins and of high caloric value. After the acute symptoms have subsided, attention should be directed to a study of the underlying psychiatric problem.

Compton Sanitarium,
820 West Compton Boulevard.

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DISCUSSION

CLINTON H. THIENES, M.D. (Department of Pharmacology, University of Southern California, Los Angeles). These are days when physicians are again becoming aware of the fact that there is a certain hazard involved in drug therapy which must be balanced against the dangers peculiar to the disease. Any remedy which is pharmacologically active is a potential poison. Bromids have been advertised as harmless, and yet it is quite apparent that physicians have given little heed to the danger of prolonged, poorly supervised bromid therapy.

In recent years there has been a renewed interest in the pharmacology of bromids, due largely to the development of simple methods of bromid determination. Of great importance are the observations on distribution of bromid in tissues and body fluids. It has been shown that most of

the bromid in the body may be found in the blood, lymph and intercellular fluid, and that the plasma contains approximately thrice the bromid ion as do the blood cells.

Malamud, Mullins, and Brown found three times as high a concentration of bromid in blood as in cerebrospinal fluid in their patients; a case of fatal poisoning examined by Vilen exhibited twice as much bromid in the gray matter of the cerebrum as in the white matter. In experimental animals the spinal fluid contains much less bromid than the blood, and the brain and cord still less. Masserman found that with blood bromid at 45 milligrams per cent, the cysternal fluid contained 11.9 milligrams per cent, and the lumbar fluid 13.4 per cent; in the total series of experiments, he found the lumbar spinal fluid to contain an average of 60 per cent higher concentration of the ion than the cysternal fluid. Bier compared different parts of the central nervous system, with this result: medulla and diencephalon, 1.5 milligram per cent, cerebellum 0.5 milligram per cent, and 0.4 milligram per cent, and cerebrum 0.3 milligram per cent.

In spite of the fact that it has been pointed out, time and again, that it is the bromid ion which is the effective radical, from the point of view of both therapeutics and toxicology, drug manufacturers continue to find profit in preparing "triple bromids," "mixed bromids," etc., for the doctor to prescribe. A rudimentary knowledge of mineral metabolism should convince the physician of the fallacy of claims for such preparations. It seems trite, but necessary, to remark that standard textbooks on pharmacology are more dependable sources of information on drug therapy than the advertiser's pamphlets.

✽

EDWARD W. TWITCHELL, M.D. (909 Hyde Street, San Francisco).—It has long been known that continued use of the bromids produced certain mental effects, and one was always warned of the possible appearance of signs of bromism. The patient became dull and sluggish, the breath became foul and the tongue coated, symptoms which disappeared when the bromids were withdrawn for some time. In fact, there were those who maintained that the after-effects of long-continued bromid medication were as bad as the epilepsy or the effects of the epilepsy itself; in other words, the remedy was worse than the disease.

Bromid delirium, however, was not so well known, and even now there are many who are not fully alive to its dangers. Bromid delirium is particularly apt to occur in the patient who is not under constant observation, but who has a bottle of bromid solution at hand which he takes oftentimes in far greater amount than he was supposed to take it. Then, without apparent reason, the psychosis develops and may go to the point of wild delirium, the true cause of which may at first be unsuspected. The situation finally clears up when the medication is stopped.

The authors deserve credit for bringing this toxic psychosis, so frequently overlooked, to the notice of the profession, and particularly for the excellent exposition of the pharmacology and the therapy based upon this pharmacology.

✽

GEORGE S. JOHNSON, M.D. (Stanford University School of Medicine, San Francisco).—The problem to which Doctors Burns and Henderson have directed attention fully deserves the emphasis placed upon it. The general usefulness of the bromids has so long been recognized that a certain false security has developed. The newly developed methods for determining blood bromid concentration have revealed the lack of correlation between blood bromid levels and those traditional signs of bromism—acne, stupor, etc. These signs may be present, but are not constant. The determination of the blood bromid level is necessary in directing the therapy in a patient who takes bromid for any considerable period of time.

Special emphasis is warranted in the case of the aged and sclerotic patient. With impaired elimination, cumulative effects are likely in this group, in which self-medication is so common. As restlessness, insomnia, and other evidence of a delirious type of reaction appear, they are met by an increase in medication which, in turn, may exaggerate the toxemia.

HUMAN STERILIZATION TODAY*

By E. S. GOSNEY, LL. B.
Pasadena

DURING the last twenty-eight years, California state institutions have sterilized nearly 12,000 insane and feeble-minded patients.

The following pages embody results shown by a case study of the first 10,000 of these sterilizations.

But first, what is sterilization?

It is a surgical operation that prevents parenthood *without unsexing the patient!*

This operation does not remove any gland or tissue. It does not interfere with any blood or nerve supply. It merely cuts and seals the tubes through which the germ cells—the spermatozoa and ova—must pass. It does not in any degree unsex the individual save to prevent parenthood. It is wholly different, therefore, from the crude and brutal operations of castration and asexualization. Primitive and pagan peoples castrated boys to produce eunuchs. Roman Catholics continued the practice until modern times, to provide male soprano voices for their cathedral choirs. Unlike these practices, modern sterilization is not a mutilation.

In men, the operation can be performed under a local anaesthetic in fifteen or twenty minutes. In women, the operation is more serious, involving the opening of the abdomen. It is thus comparable in severity to an uncomplicated operation for chronic appendicitis. It means a week or two in bed. In either sex, failures are almost unknown.

EUGENIC STERILIZATION IS NOT AN EXPERIMENT

Eugenic sterilization in this form represents one of the greatest advances in modern civilization. It is not a novelty or an experiment. It has been continuously used by American institutions since 1899, when the first sterilizations were performed in Indiana.

More than 130,000,000 people, including the citizens of twenty-nine American states, are now living under eugenic sterilization laws. Apart from the United States, the countries which have adopted such legislation are the Canadian provinces of Alberta and British Columbia; Norway; Sweden; Denmark; Finland; Esthonia; Germany; the Free City of Danzig; the state of Vera Cruz, Mexico; and the Canton of Vaud, Switzerland.

The following table shows the American states that now have sterilization laws in force, with the year of the adoption of the first statute:

Alabama	1919	Nebraska	1915
Arizona	1929	New Hampshire	1917
California	1909	North Carolina	1919
Connecticut	1909	North Dakota	1913
Delaware	1923	Oklahoma	1931
Georgia	1937	Oregon	1917
Idaho	1925	South Carolina	1935
Indiana	1907	South Dakota	1917
Iowa	1911	Utah	1925
Kansas	1913	Vermont	1931
Maine	1925	Virginia	1924
Michigan	1913	Washington	1909
Minnesota	1925	West Virginia	1929
Mississippi	1928	Wisconsin	1913
Montana	1923		

* A reprint of a publication of the Human Betterment Foundation, 321 Pacific Southwest Building, Pasadena. See also article on "Human Betterment" in May, 1937, issue, page 296, by Dr. Edward M. Pallette, retiring president of the California Medical Association.

THE PROBLEMS BEFORE AMERICAN CITIZENS

The situation which has led all these commonwealths to adopt sterilization laws grows out of such facts as the following:

Births among families living on public charity are often 50 per cent higher than births among self-supporting families.

The families that contribute children to the state homes for the feeble-minded in California are multiplying about twice as rapidly as the rest of the population.

The burden of taxation due to the mentally diseased and mentally defective is at the same time steadily mounting.

Few of the feeble-minded are given institutional care, but their presence in the population at large is none the less expensive both in direct costs and in lowered efficiency of industry, in crime and delinquency, and in the deterioration of citizenship which is inevitable when a large number of the citizens are mentally abnormal.

Psychologists estimate that at least 1,000,000 persons in the United States are so feeble-minded as to need special care and supervision. If anyone with less than 70 per cent of average intelligence for his age is called mentally deficient, the number of such persons in the United States is found to be about 6,500,000.

The number of insane persons in hospitals is growing from year to year. Only 435,000 are cared for at any one time, but the turnover is rapid, 95,000 new admissions being reported each twelve months. Statisticians have calculated that nearly 5 per cent of the American population or 6,000,000 people will at some time during life be legally committed as insane. But there are many who break down to an equal degree, enough to prevent them from carrying on their regular work, but who are not committed to hospitals by the courts. Calculations by Dr. W. F. Ogburn of the University of Chicago show that these amount to an additional 5 per cent, making the total number of mentally diseased about 10 per cent of the entire population.

EUGENIC STERILIZATION IS NOT A PANACEA

Sterilization is no panacea for these ills of mankind, but it is one of the many measures indispensable to any far-sighted and humanitarian program for dealing with society's tremendous burden of mental disease, deficiency, and dependency.

The principle of compulsory sterilization by the state, under proper safeguards, was upheld as constitutional by the Supreme Court of the United States in the case of *Buck vs. Bell* (1927). In writing the decision, Justice Oliver Wendell Holmes remarked: "Three generations of imbeciles are enough."

Agreeing with this view, state after state is now extending the application of sterilization to such of its defectives as are legally committed to state institutions. In this practice, every state benefits by the experience of California, studied intensively and continuously since 1925 by the Human Betterment Foundation.

The first study (1926-1929) covered 6,000 California sterilizations. Its details were published in

a score of technical papers in various scientific journals. A bound volume of these, entitled "Collected Papers on Eugenic Sterilization in California," is accessible in most of the important libraries of America. A more popular digest of the facts was published in 1929 by The Macmillan Company, New York City. This book, entitled "Sterilization for Human Betterment," by E. S. Gosney and Paul Popenoe, can be had for \$2 through any bookstore or from this Foundation.

A second complete study (1932-1936) brought the subject up to date and confirmed the findings of the first study. Full results are reported in a booklet entitled "Twenty-eight Years of Sterilization in California," which is being published the middle of this year.

STERILIZATION IS APPROVED BY ALL

The most striking revelation from our studies is the extent to which the policy of eugenic sterilization is approved by those who know most about it.

Patients, relatives of patients, state officials, physicians and surgeons, parole and probation officers, social workers, agree on the value of this practice.

It is a protection, not a punishment, and therefore carries no stigma or humiliation.

It permits many patients to return to their homes without danger of producing handicapped children. It thus keeps homes together by removing the threat of defective offspring, prevents the break-up of families, and relieves the California taxpayers of a burden estimated at more than \$2,000,000 per year. Even among the feeble-minded, at least two-thirds of the sterilized and paroled patients adjust themselves successfully to life outside the institution.

SEX OFFENSES LESS FREQUENT

Sterilization has been followed by a marked decrease in sex offenses. This is not because the operation changes the sexual life, for it produces no such change. It is because of better health, educational discipline, careful placement, and supervision on parole. But the record once for all disposes of the charge that sterilization will result in increased promiscuity and the spread of venereal diseases. Just one illustration: Of 304 feeble-minded girls sterilized and paroled, nine out of every twelve had been sex offenders before commitment. After sterilization, only one out of every twelve became sex delinquent on parole.

Sterilization prevents the birth of children who, even if not defective, would otherwise be brought up in unfavorable environments by mentally diseased or mentally deficient parents or by the state. It enables many handicapped persons to marry and to have a life normal in most respects, whose marriage otherwise would be unwise if not disastrous. A study of marriages of 130 feeble-minded patients after sterilization and parole shows that two-thirds of them have been successful. This is as good as the record of all California marriages.

STERILIZATION IS HIGHLY SELECTIVE

It must be understood that not everyone who is sent to a state institution is sterilized. Mass sterilization has no place in this program. Each case is

judged on its own merits. Of the feeble-minded who have been paroled, about one-half have been sterilized. Of the persons admitted to state hospitals for the insane, one in six of the new admissions is sterilized before leaving. Selection of the patients for this operation is made after careful study by medical specialists, and usually with the written consent of the nearest relatives.

Sterilizations in California have been about equally divided between men and women. Two-thirds of the number sterilized were committed as insane, the remainder as feeble-minded.

The consistently careful administration of this measure in California is reflected by the fact that during the first six years sterilizations per year increased from 11 to 116; total, 577; a yearly average of 96. During the succeeding years they have gradually increased from 182 in 1915 to the peak of 874 in 1935. The average during the past two decades has been 537 per year.

WHAT IS THE HUMAN BETTERMENT FOUNDATION?

The Human Betterment Foundation is a non-profit corporation, organized under the laws of California. Its members, eminent in a wide range of professional and business activities, are as follows (members of the Board of Trustees being marked with an asterisk):

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- Oscar Ford, Former Mayor of Riverside, Riverside.
- Paul McBride Perigord, University of California at Los Angeles, Los Angeles.
- R. B. Von KleinSmid, President of University of Southern California, Los Angeles.

This organization is not designed to take up original scientific research work, but rather to investigate the results and possibilities for human betterment by a safe, conservative application of the discoveries made by scientists, and to give this information to the public.

Its first major problem is to investigate the possibilities for race betterment by eugenic steri-

lization, and to publish the results. When the public is familiar with these facts, some other major subject will be substituted. The scope of the Foundation is as broad as its name indicates. It is restricted only to conservative, preventive work for humanity as distinguished from ordinary charity relief work or patchwork. Its goal is the constructive, practical advancement and betterment of human life, character, and citizenship, in such manner as to make for human happiness and progress.

The possibilities of fundamental, constructive, preventive work along these lines are broad. They are limited only by the ability and number of workers.

This Foundation is not designed to perpetuate any name or to be a monument to any individual or family; but to be a center from which effective, constructive work can be carried on by all who feel the importance of such work and are in a position to help either by the contribution of capital or by the contribution of talent. The articles of incorporation leave the future free from undue limitations of organization and policy.

The officers and trustees of this Foundation will be glad to confer with anyone who is interested in the work above outlined, or who may wish to use the opportunity afforded by this organization to realize his own ideals in the promotion of race betterment.

Suite 321, Pacific Southwest Building.

*Eugenic Sterilizations Performed in State Institutions
Under State Laws Up to January 1, 1937*

State	Male	Female	Total
Alabama	129	95	224
Arizona	10	10	20
California	5,933	5,551	11,484
Connecticut	23	372	395
Delaware	263	231	494
Idaho	4	10	14
Indiana	321	228	549
Iowa	61	46	107
Kansas	1,039	711	1,750
Maine	14	115	129
Michigan	381	1,315	1,696
Minnesota	224	1,054	1,278
Mississippi	99	223	322
Montana	34	62	96
Nebraska	123	189	312
New Hampshire	45	281	326
*New York	1	41	42
North Carolina	65	325	390
North Dakota	84	250	334
Oklahoma	42	113	155
Oregon	378	727	1,105
South Carolina	0	0	0
South Dakota	110	194	304
Utah	46	60	106
Vermont	41	98	139
Virginia	1,077	1,557	2,634
Washington	31	165	196
West Virginia	0	10	10
Wisconsin	96	696	792
Totals	10,674	14,729	25,403

1. The above figures were furnished by state authorities.

2. In many states lacking sterilization laws, the state institutions sterilize patients with consent. No account is here taken of such operations, nor of those that are primarily therapeutic, not eugenic, in purpose.

3. These reports show an increase of official sterilizations in the United States for the year 1936, of 2,241.

Georgia has just enacted (1937) a sterilization law.

* The New York law was declared unconstitutional in 1918.

Addenda

DISTINCTIONS BETWEEN STERILIZATION AND "BIRTH CONTROL"

There is a wide difference between sterilization and "birth control" by contraception. Unless this difference is recognized in any study of the subject, no reliable conclusions involving both can be drawn.

Eugenic sterilization, primarily, is applied by the state or with its sanction, to persons who would be likely to produce defective children. It protects such persons, their potential children, the state, and posterity. Such persons may not have the intelligence, the foresight, or the self-control, to handle contraceptives successfully, nor the ability to care for children intelligently. Sterilization is practically irreversible—permanent—and 100 per cent effective. It is the only reliable method of birth control which many defectives can use.

Birth control by contraceptive methods is voluntary and applied by the individual for his own purposes. It requires extreme care, intelligence, and a practical biological understanding of the problem. When not applied under definite instructions from a competent, experienced physician or nurse, after examination, it frequently results in failure. At best, what succeeds with one may fail with another, especially with the young and inexperienced.

Both sterilization and contraception have a place in modern society. Both demand careful consideration, but they apply to different classes of people and for different reasons. They should never be confused as merely parts of one program. The best results of each will be promoted by a frank recognition of their differences and the limitations of each.

THE LURE OF MEDICAL HISTORY†

JOSEPH POMEROY WIDNEY, A.M., M.D.,
D.D., LL.D.*

FOUNDER OF THE LOS ANGELES COUNTY MEDICAL
ASSOCIATION AND OF THE COLLEGE OF MEDICINE
OF THE UNIVERSITY OF SOUTHERN CALI-
FORNIA; OLDEST LIVING GRADUATE OF
THE UNIVERSITY OF CALIFORNIA
(TOLAND MEDICAL COLLEGE, 1866)

UNVEILING OF BRONZE BUST OF DOCTOR WIDNEY

A MOST unusual event took place at the Los Angeles County Medical Association Tuesday noon, May 11.

The founder of the Los Angeles County Medical Association, who also founded the School of Medicine of the University of Southern California—Joseph Pomeroy Widney, A.M., M.D., D.D., LL.D., physician, soldier, leader, scholar, statesman, and grand old man of medicine—now

† A Twenty-five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* For biographical notes concerning Dr. Joseph P. Widney, readers are referred to CALIFORNIA AND WESTERN MEDICINE (April, 1936, page 292, and May, 1936, page 396).

in his ninety-seventh year, attended a luncheon meeting, at which time a bronze bust of himself was unveiled.

Doctor Widney then paid the assemblage the high honor of addressing them on a subject that all through his long life has remained closest to his heart, "The Science of Medicine."

Unusual again is the fact that this bust of Doctor Widney was created by one of the newer graduates of the school of medicine which Doctor Widney founded. The artist is Dr. Emil Seletz, who was also a guest of honor with relatives of Doctor Widney at the luncheon; and his bust has won the recognition of famous sculptors in this country, including George Grey Barnard, who entitled the masterpiece, "The Great Prophet."

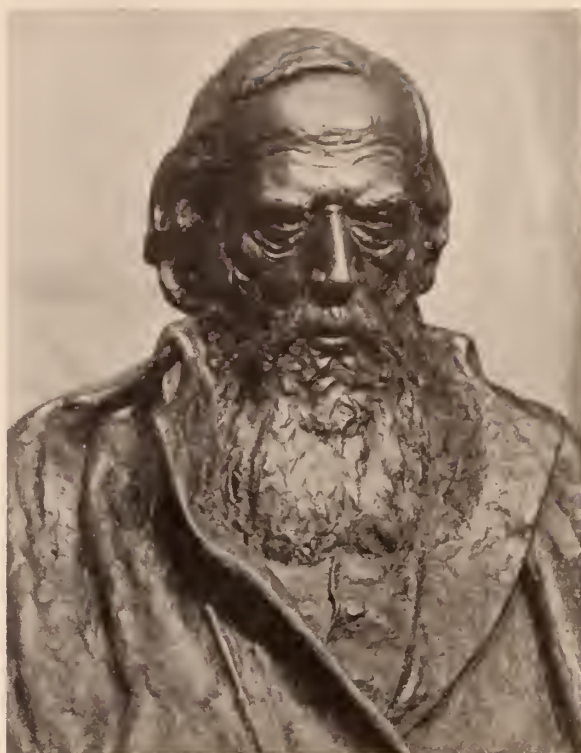
Doctor Widney's message to the profession at this memorable meeting follows:

"I wish, first of all, to thank my associates in the medical profession for the honor they have conferred upon me this day. I appreciate highly the personal friendships it expresses. I have had many friends among my associates of the profession. I know of no enemies. It is a pleasure to me to be able to say this after seventy years spent in the active prosecution of the science of disease—its causes, its prevention. That the physician cures disease might be questioned. That disease may be prevented or successfully led to a favorable ending is beyond question. This is the broader field. In this broader sense, I have never retired from the active practice of the science of medicine; but have patiently, painstakingly, thoughtfully been seeking for the causes which lie back of disease. When I received my diploma—and it came with the honors of the class—two factors had been impressed upon me, the diseases of the man physical and the drug store as the cure-all. I doubted as to the major importance of both. It seemed to me the field was broader than that.

"In press now I have another work—'Civilizations and Their Diseases. Why Do They Die?' And as a sub-topic, another question—'Religions and Their Diseases. Why Do They Die?' It is the instinct of the trained physician that lies back of these books. It is the diagnosis. Then comes another volume, 'The Rebuilding of a Wrecked Civilization.' It is the medical treatment of the case.

"And the prognosis? That while civilizations and religions may die, Civilization and Religion will live on. It is the law of growth. And man has not yet finished his life upon this globe.

"There is one book yet to be completed, for it is now partly written—'Life and Its Problems, as Seen by a Blind Man at Ninety-Seven.' In this book, the search passes out beyond our globe to the globes of many constellations, so distant that the ten-foot reflectors show them as only patches of light. Such questions will arise as 'Life, What Is It? Whence? Whither? Wherefore? When the boundaries of the Universe are reached, what lies beyond? When time shall be no more, what comes after?' And then, the vital question, 'What, in the present stage of man's existence, is the limit of the knowable?'



Bronze Bust: Joseph Pomeroy Widney, M.D., Founder of the Los Angeles County Medical Association. Sculptor: Dr. Emil Seletz, member of the Los Angeles County Medical Association

"I soon found that by the side of the man physical was a man intellectual and that this man had to be taken into consideration as well as the man physical, and that, too, in every case. They could not be separated and they mutually influenced each other.

"I was called to the bedside of a young woman, handsome and strong and really not very sick, although she thought she was. I was looking into the face of a frightened animal, terror-stricken at the thought of death. A wolf at bay in the chase may look like that and over this the drug store had no power. Cases like that soon turned me to the quest for something higher than drugs in the cure of disease. My mental life began to shape itself more and more along the line of research into the underlying principles of disease. I wanted causation. It was the eternal—Why? Then began my part in the educational work. One lesson I always impressed upon the students in their educational work: 'Never be satisfied unless you have found the cause of the disease. You may not find it, for Medical Science is yet incomplete, still in the empirical stage; but be dissatisfied with yourself if you have failed to keep on trying.'

"I found still another fact, that, by the side of the man physical and the man intellectual, is yet another—the man spiritual. And he, too, must be considered in the curing of the disease. Some of my friends have wondered why I entered the ministry in mid-life. It was not that I was abandoning the Science of Medicine. It was only that I was broadening the field of research. I wished opportunity for clinical study into the souls of



Dr. Joseph P. Widney, the bronze bust of Doctor Widney, and Dr. Emil Seletz. Taken at the time the bust was unveiled on May 11, 1937

men. This could best be found among the churches. I carried this line of research among the velvet-cushioned pews of the rich and respectable, and in the slums of the poor and disreputable. I gave years to this, and everywhere that soul was the same. Environment had made the difference. Then came the curative question, 'How may the environments be improved?' and here, the drug store had no place.

"The field still kept broadening. I found men, differing in types of race life, differing physically, differing intellectually, differing spiritually; and yet having sprung from one common race stock in some original race home. It is so that the old Proto-Aryan of the Uplands of Asia, leaving his land, ages ago as one, has peopled Europe with a progeny so diversified, so unlike each other that we can hardly believe they came from the one primitive stock; and they differ in the types of diseases which they develop. The goitre of the Swiss Alps is not found along the shores of the Mediterranean. Scrofula and consumption of Mid-Europe, with its diet of pork, are less frequently found with the olive and the tart wines of Italy and France. Again comes the eternal — Why? The answer lies, again, in the one word, Environment. And now, Medical Science is dealing not with the individual man, but with races. And now, also, Medical Science, in its researches is dealing—not with the drug store—but with earth problems—physiography, geology, climatology, and is reaching back to the primitive man, and the ice-sheets and earth fissures, into a world life that is ever transforming and re-transforming itself. These settle the fate of the races. We find that peoples upon the earth have appeared, lived their race lives and are gone, leaving only some carven stones or rude monoliths to tell that ever they lived.

"The *elephas giganteus* and the saber-toothed tiger and the cave bear have disappeared with those older races. They shared a common fate. And again comes the eternal Why? Medical Science must help to solve the problem. And again, away back at the beginning of the long, long trail is the glimmer of the green bottle of the apothecary's window. To the credit of the medical profession, it may be said, the search began there. And over the broad earth, in every department of research, into the evolution of man and of globes, the men of medical training are in the lead.

"The books which, for fifty years, I have been slowly thinking out, I am now elaborating and publishing. Through them all runs one connecting thought.

"In the recent years of blindness, sitting alone in the dark, I have been slowly thinking it out. These books are my contributions."

THE CALIFORNIA STATE BOARD OF PUBLIC HEALTH*

CALIFORNIA'S STATE BOARD OF HEALTH, THE
SECOND TO BE ESTABLISHED IN THE
UNITED STATES

By GUY P. JONES
Sacramento

THE California State Board of Health was organized by statute April 15, 1870. It was the second such board to be established in the United States, the Massachusetts State Board of Health having been organized but six months earlier. Dr. Thomas M. Logan, a native of Charleston, South Carolina, and later a resident of New Orleans, was primarily responsible for the organization of the California State Board of Health. He arrived in Sacramento in 1850 and resided there continuously until his death in 1876. Almost single-handedly he put through the legislation for the organization of the California Board and became its first secretary, remaining in this post until his death.

PERIOD: 1870 TO 1905

The activities of the Board from the beginning, in 1870 until 1905, were conducted solely by seven doctors of medicine, who held meetings at least quarterly, generally oftener. During these years serious problems in the prevention of communicable disease were encountered. The appearance of plague in 1900 and again in 1908 produced major crises which jeopardized the cordial relationship between California and the rest of the states.

PERIOD: 1905 TO 1929

In 1905, upon the accession of Dr. George C. Pardee of Oakland to the governorship of California, Dr. N. K. Foster became secretary of the State Board of Health. With the appointment of Doctor Foster, the State public health organi-

* From the office of the Chief of the Division of Vital Statistics, California Department of Public Health.

zation developed into a practical and efficient organization. Under Doctor Foster's régime, laws pertaining to the establishment of standards for pure foods and pure drugs were enacted, the state-wide registration of vital statistics began, and the State Bacteriological Laboratory was founded. The structure of the organization, by bureaus, was started.

During the years that followed, other public health activities have been developed and have become part of the standard plan for protection of the public health. Among these are sanitary engineering, tuberculosis control, child hygiene, registration of nurses, sanitary inspection, cannery inspection, relief for the physically handicapped, and many other activities.

REORGANIZATION IN 1929

In 1929, under a reorganization of the State government into departments, the California State Department of Public Health was organized and the State Department of Health that had functioned for so many years became the State Board of Public Health. Under the laws then enacted the State Department of Public Health was placed under the control of the State Board of Public Health, where it has since remained.

THE SIX DIVISIONS OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

The Department is organized into six divisions: Administration, Communicable Diseases, Public Health Education, Laboratories, Sanitation, and Vital Statistics. Following is an outline of the general type of activities that are carried on by the various divisions and bureaus of the Department:

(a) Under the Division of Administration are carried on activities to assist local health departments, finance, crippled children, publicity, and statistical service.

(b) Under the Division of Communicable Diseases are grouped activities of the Bureau of Epidemiology (including morbidity registration) and the Bureau of Tuberculosis.

(c) Under the Division of Public Health Education are grouped the activities of the Bureau of Child Hygiene, Bureau of Registration of Nurses, and the Bureau of Public Health Nursing.

(d) Under the Division of Laboratories are grouped activities relating to the bacteriological diagnosis of communicable diseases, food and drug examinations, research, water and sewage examinations.

(e) Under the Division of Sanitation are grouped the activities of food and drug law enforcement, the Bureau of Cannery Inspection, Bureau of Sanitary Inspections, Bureau of Sanitary Engineering (including mosquito control).

(f) Under the Division of Vital Statistics, the registration of births, deaths, and marriages is carried on.

I. DIVISION OF ADMINISTRATION

Finance.—Keeps records of all income and expenditures. Prepares budgets and estimates of

expense. Prepares and submits claims to Department of Finance and State Controller.

Crippled Children.—Conducts searches for crippled children who may be amenable to the provisions of the so-called Crippled Child Act. Conducts diagnostic clinics and conferences, and follows up cases of crippling diseases. Provides for treatment of physically handicapped whose parents or guardians are unable to provide treatment, if certified by the superior court of the county within which the crippled individual resides.

Publicity and Statistical Service.—The law provides for publishing statistical and other information which may be of value to scientists, medical profession, and the general public in the maintenance of proper health conditions. A weekly bulletin providing such information is published and distributed to all individuals who may require it. A biennial report is published. Special bulletins and circulars are issued as occasion may require. Newspapers are provided with material of current interest and value in the maintenance of the public health. Public health exhibits are prepared. Special information and special statistical data are provided, as requested.

II. DIVISION OF COMMUNICABLE DISEASES

Bureau of Epidemiology.—The law requires that action be taken, as necessary, to protect and preserve public health, and requires the reporting of certain classes of communicable diseases, as well as other diseases which may be specified by the State Board of Public Health. Health officers are required to send reports at the end of each week. From these reports morbidity statistics are compiled and distributed. Epidemiologists are available at all times for the investigation of outbreaks of communicable diseases. Assistance is given in the demonstration of various procedures that may be of use in the prevention of disease. Efforts are made continuously toward the provision of safeguards against the introduction of communicable diseases from other states and foreign countries.

Bureau of Tuberculosis.—The Board is charged with the preparation of rules and regulations for the administration of tuberculosis sanatoria within the State, and the law requires the State Board of Public Health to administer the State subsidy to counties which maintain the required standards in county tuberculosis sanatoria. All tuberculosis sanatoria, both public and private, are inspected regularly. In addition, special clinics for the discovery of tuberculous cases among certain groups of individuals are carried on. Surveys are made of communities to determine the extent of tuberculosis. Literature relating to the prevention of the disease is distributed. Exhibits are maintained and an informational service is provided for the benefit of the general public.

III. DIVISION OF PUBLIC HEALTH EDUCATION

Bureau of Registration of Nurses.—The State Board of Public Health is required to examine eligible candidates for registration as nurses; to conduct examinations for their registration; and

to maintain standards of reciprocity in the registration of nurses from other states without examination. Training schools for nurses are inspected and prerequisites are determined for the eligibility of candidates desiring examination. An informational service is maintained for the benefit of both training schools and student nurses.

Bureau of Child Hygiene.—Under the law the State Board of Public Health is charged with the investigation of conditions affecting the health of children in California and with the dissemination of educational information relative to the health of children. The law also requires the board to inspect and license maternity homes and hospitals. Infants and children in rural communities are provided with physical examinations only where such examinations are not available. A wide variety of literature pertaining to these and related subjects is distributed. Maternity homes and hospitals are inspected and recommended for licensure. Institutes on child care, prenatal, and maternity care are conducted.

IV. DIVISION OF LABORATORIES

Bacteriological Laboratory.—The law requires the maintenance of a laboratory for bacteriological examinations at the University of California in Berkeley. Diagnostic examinations are made of specimens from individuals in whom communicable diseases may exist. This service is available to all physicians and health officers, except for those in cities having populations of 20,000 and over. The laboratory manufactures typhoid vaccine for free distribution to physicians, as well as antigens and similar products to other laboratories at nominal cost. Outfits containing two ampules of silver nitrate are manufactured in the laboratory and distributed free of charge to physicians and midwives for administration in the eyes of the newly born for the prevention of ophthalmia neonatorum.

Food and Drug Laboratory.—A laboratory is also maintained at the University of California where samples of foods and drugs are analyzed. In addition to official samples, many unofficial samples are examined. Most of these are of food materials supplied to state institutions. Such samples are purchased under contract and the laboratory makes frequent analyses in order to provide assurance that state wards receive foods which conform to required standards.

Water and Sewage Laboratory.—For the benefit of purveyors of water supplies, a laboratory is maintained where bacteriological checks upon the quality of water supplies are made. This service is available to all municipalities which may need it. The efficiency of sewage disposal plants is also checked through examinations of sewage which are made whenever they may be required by any community.

Hooper Foundation for Medical Research.—Through the coöperation of this institution, which is connected with the University of California School of Medicine, a large amount of research work is accomplished in the control of the more rare communicable diseases. Since it is equipped for accomplishing work of the highest order,

which is not available at any other place in the state, an added safeguard in the prevention of communicable diseases is provided. The coöperative efforts of the institution and its director, Dr. K. F. Meyer, have been particularly beneficial in the study of psittacosis, relapsing fever, botulism, meningitis, epidemic poliomyelitis, shellfish poisoning (particularly clams and mussels), and other diseases.

V. DIVISION OF SANITATION

Bureau of Food and Drug Inspections.—The state law requires that such duties, as may be essential, shall be performed for the detection and prevention of adulteration of articles used for food and drugs, and for the punishment of persons guilty of violation of any law providing against such adulteration. There are also many acts of the legislature pertaining to the control of foods, among which are those pertaining to cold storage, egg standardization, feeding stuffs standardization, etc. Samples of foods and drugs are gathered and analyzed in the laboratory, to determine if they are mislabeled or adulterated. Inspections of food and drug establishments are made to determine sanitary conditions and to determine, also, if their products conform to the food and drug laws. A bureau of information is conducted for the benefit of manufacturers and distributors of food and drug products. Advice relative to proper labels and methods of manufacture is given. Products held in cold storage are inspected. Many tons of food products, which are found unfit for human consumption, are condemned and destroyed. Special attention is given to manufacturers, in order that food supplies at their sources may be found to comply with the laws. This policy works in the interest of the general public and in that of the retail dealer, as well.

Bureau of Cannery Inspection.—All packers of meat and vegetable products in whose plants steam sterilizers and retorts are maintained, must secure licenses for the operation of such equipment from the State Board of Public Health. Operators of such equipment must also obtain permits from the board. Special regulations for the operation of canneries and the proper sterilization of products packed in such places have been developed and are enforced by the bureau. In all canneries which come within the scope of this law, inspectors are provided, whose duty it is to pass upon the quality of the raw product and to check the records pertaining to cooking and sterilization of such products throughout the canning process. No state funds are appropriated for this work, the service being provided by the canning industry at its own expense.

Bureau of Sanitary Inspections.—Regulations pertaining to food sanitation, domestic sewage disposal, garbage disposal, and the abatement of nuisances are explicit, and cover a wide range of duties pertaining to the maintenance of general sanitation throughout the state. A staff of sanitary inspectors receives complaints of insanitary conditions, makes inspections, and provides machinery for the abatement of nuisances which may

be discovered. The bureau coöperates with local health officers in the maintenance of sanitary conditions in their communities, and makes sanitary surveys of towns, cities and rural communities, as required. It undertakes special activities pertaining to the control of rabies in dogs, plague in rats and ground squirrels, and similar undertakings. Proper disposal of garbage and domestic sewage constitute a large part of its work.

Bureau of Sanitary Engineering.—The law requires a permit from the State Board of Public Health for the operation of any community sewage disposal plant or water supply system. A staff of sanitary engineers passes upon plans for sewage disposal plants and water supply systems, which must be submitted, together with application for a permit to operate. Field inspections of all such plants are undertaken, advice is given relative to the engineering process involved, and recommendations for the issuance of permits are made to the State Board of Public Health. In addition, surveys are made of shellfish-growing beds, and the board's regulations pertaining to the growing of shellfish are enforced. Another activity of the Bureau of Sanitary Engineering is that pertaining to the control of mosquitoes. The bureau coöperates with the twenty-five mosquito-abatement districts which are organized and operate in the various counties of the state. Advice and assistance are given in these districts.

VI. DIVISION OF VITAL STATISTICS

The registration of vital statistics is an important function of the State Department of Public Health. All birth, death and marriage certificates that may be recorded locally in California are sent each month to the office of the chief registrar at Sacramento. All of these records are indexed in order that they may be found on file, if needed for legal or other purposes. State registration of births, deaths and marriages began in July, 1905, and since that time more than six million names have been placed upon the general index. Statistics relating to births, deaths and marriages are compiled regularly and published. This bureau is the vital bookkeeping office of the department. Through proper use of the data supplied by this bureau, the trend of public health generally throughout the state is determined.

VII. ACCESSORY FUNCTIONS OF THE STATE BOARD OF HEALTH

In addition to the duties of the State Board of Public Health as performed through the organized functions of the State Department of Public Health, other duties have been added to its administrative program during recent years. The inspection and licensure of clinics and certification of nonprofit hospitals that may comply with required standards are the newest of such duties imposed by law. The functions of the board that pertain to inspection, certification and licensure are expanding with each session of the legislature, and the regulatory duties of the board are becoming, upon public demand, more intensive each year. Among the licenses, permits, and certificates now issued by the board are the following:

- Certification of registered nurses;
- Certification of public health nurses;
- Certification of proficiency as laboratory technicians in (a) Bacteriology, (b) Serology, (c) Parasitology, and (d) Biochemistry;
- Certification of approval to bacteriological laboratories;
- Certification of nonprofit hospitals of required standards;
- Permits for municipal or corporate sewage disposal;
- Permits for municipal or corporate water supply;
- Licenses to operate cold storage warehouses;
- Licenses to canneries, using steam retorts (vegetable and meat products);
- Licenses to operate steam retorts in certain canneries;
- Licenses to conduct aviaries;
- Licenses to conduct clinics; and
- Licenses to operate maternity homes and hospitals.

401 State Office Building, Sacramento.

CLINICAL NOTES AND CASE REPORTS

INTERLOCKING OR COLLISION OF TWINS— DYSTOCIA—LOW CESAREAN DELIVERY

By LINDSAY PETERS, M.D.

Alameda

THE Index Catalogue of the Surgeon-General's Library, covering world-wide medical literature from 1912 to 1932, lists only three titles referring to collision or locking of twins. One of these is a separate treatise; the other two, reports in medical journals, including a total of three cases (all in Swedish literature). I have been unable to find a single report of this complication in American obstetrical literature, outside of casual references in textbooks. A definite statement of the infrequency of the condition is found in an article by Coleman, who reports two cases* and quotes from Eden and Holland's Manual of Midwifery, London, 1925, page 358, as follows: "According to Von Braun, the condition occurred only once in 90,000 deliveries in Vienna."

REPORT OF CASE

The rarity of the complication, as shown by the above facts, suggests the desirability of recording the following case:

History.—On February 12, 1936, Mrs. J. B., white, aged seventeen years, placed herself in my care for her first pregnancy. There was no history of multiple birth in her own, nor in her husband's, family. Her last menstruation began September 20, 1935. Except moderate nausea and vomiting during one month, she had felt very well. Otherwise her history was devoid of interesting data.

Physical Examination.—She was a small girl, her weight before pregnancy having been ninety-two pounds. At her first visit her weight, with clothing, was 101½ pounds. Hemoglobin, 70 per cent (Talquist). Urine negative for albumen and sugar. Teeth good. Tonsils

* J. S. Coleman, M. B., *Lancet*, January 25, 1936, p. 196.



Fig. 1.—The relative positions of the twins shown forecast the danger of collision and locking when the breech descends and the two heads attempt to enter the pelvis at the same time.

normal. Thyroid normal. Breasts and nipples well formed. Heart normal. Lungs normal. Abdomen normal. Fundus midway between symphysis and umbilicus. Vulva nulliparous, normal. Cervix conical, soft, normal. Pelvic diameters: interspinous, 24 centimeters; intercrystal, 20 centimeters; bitrochanteric, 29 centimeters; Baudeloque's, 17 centimeters; bischial, 10.5 centimeters; diagonal conjugate (?) (unable to reach sacral promontory).

On May 15, 1936, the patient reported a pruritic eruption, of two or three days' duration, showing first on the abdomen, then extending to the lower and upper limbs. This was found to be urticaria, the cause of which was not ascertained. It was alleviated by alkalizing diet and alkaline topical applications.

At this time the abdomen was seen to be greatly enlarged. Fetal small parts were felt on both sides of the front of the abdomen. No fetal head could be felt at either pole, either by abdominal or vaginal palpation. A fetal heart was distinctly heard in the right flank, slightly below the level of the umbilicus. At one time it was thought that another heart was heard in the upper, left quadrant, where there was a loud placental bruit, but it was not definite.

On account of the inability to locate a fetal head, together with the apparently sudden increase in size of the abdomen, suggesting hydramnios, the possibility of an encephalus was thought of, in addition to the possibility of plural conception.

Subsequent Course.—On May 16 an x-ray examination showed twins, one presenting by the breech, the other in cephalic presentation, with the head in the left iliac fossa, being displaced by the breech, which occupied the pelvic cavity.

The relative positions of the twins made one anticipate a probable collision of the heads at the pelvic inlet during labor, and this was discussed with some who saw the film. However, it was thought best not to interfere unless the necessity arose.

Labor began June 14, 1936, with rupture of the membranes about 7 a. m. On arriving at Alameda Sanatorium, about 11 a. m., it was now possible, since the membranes had ruptured, to palpate the two fetal heads and to hear the two hearts. The positions were the same as shown in the x-ray film. Rectal examination showed the breech in the upper part of the pelvic cavity, the cervical canal obliterated and dilatation 2.5 centimeters diameter. Contractions, about every ten minutes, were not painful. About 9 p. m. the patient began to cry out with pains; there was a bloody show and the patient was taken to the

delivery room. On account of poor uterine contractions no analgesic was given, except whiffs of ether during pains. The breech gradually came down so that by 10:30 p. m., by separating the lower vaginal walls, it could be seen, almost on the pelvic floor. From this time onward there was no progress in the labor, and at 11:30 p. m. the patient, showing fatigue from long suffering, was etherized; and, after episiotomy, exploration showed the two heads interlocked at the pelvic brim, the cephalic presentation preventing descent of the head of the child in breech presentation. As it was found impossible to push up the obstructing head, this "collision" and locking of the heads made delivery through the vagina impossible without mutilation of at least one child. Abdominal delivery was, therefore, clearly indicated.

The patient was taken to the operating room, and about 12:45 a. m., under ether, a 14-centimeter midline abdominal incision, extending from pubis to umbilicus, was made. There was diastasis of the recti, and the abdominal wall was very thin. The peritoneal cavity was opened high up to avoid the bladder, and the incision was then extended down to near the pubis. Retracting the bladder forward, the vesical reflection of the peritoneum was incised transversely to the extent of 9 centimeters in order to make upper and lower flaps, exposing the uterine wall underneath. After freeing the bladder from the uterus by blunt dissection as far down as possible, a low, longitudinal incision was made through the anterior wall of the thinned-out cervix and a short distance into the lower uterine segment. The child presenting by the breech was first delivered by pulling up the breech. This offered no difficulties. The head of the second child then presented in the wound; and, after rupturing its amniotic sac, was easily delivered. Pituitrin had been given just before incising the uterus, and bleeding after delivery of both children was negligible until the placenta was manually stripped from the upper, posterior uterine wall, when there was sharp hemorrhage, requiring packing of the uterus to control it. Considerable amounts of fetal membranes were found adherent to the uterine walls, and these were removed as completely as possible. The uterine wound was closed by two layers of chromic catgut, No. 2, for the inner layer, and No. 0 for the outer. The cervical portion was so thin that it was difficult to close without including endometrium in the sutures. The flaps of visceral peritoneum and also the parietal peritoneum were brought together with continuous sutures of fine, plain catgut. The fascia was united by a continuous suture of No. 2 chromic catgut, reinforced by two silkworm gut sutures, which included skin, fat, and fascia. The skin was closed with a continuous suture of fine dermal.

On account of the rather free bleeding after removing the placenta, 1,000 cubic centimeters of 10 per cent dextrose solution in normal saline was given immediately by vein. There was a moderate bloody vaginal discharge, and ergoklonin, one dram in water, was given by rectum. After returning the patient to her room, Murphy drip 1,000 cubic centimeters, with coffee and glucose, were given.

Both infants were females. They did not breathe promptly, but were of good color and easily made to breathe.

Weights and measurements:

	No. 1 (Breech)	No. 2 (Cephalic)
Weight.....	5 lbs. 4½ ozs.	4 lbs. 6½ ozs.
Length.....	45 cm.	45 cm.

Head diameters:

Occipito-frontal	10.5 cm.	10 cm.
Suboccipito-bregmatic	8.75 cm.	8.75 cm.
Occipito-mental	12 cm.	12 cm.
Biparietal	9 cm.	8.25 cm.
Bitemporal	8 cm.	7.5 cm.

Postoperative.—During the first twelve hours postoperative, the patient was nauseated and vomited several times. This was relieved by 1,000 cubic centimeters of 10 per cent dextrose in normal saline given intravenously. Then 4 per cent solution of mercurochrome was instilled into the vagina daily. As the postoperative temperature had not exceeded 100 degrees Fahrenheit and the pulse ranged between 90 and 100 plus, of good quality, on account

of financial considerations the patient was allowed to be taken to her sister's home by ambulance the night of June 17. The temperature and pulse continued about the same as previously; the patient was comfortable and apparently doing well when, on June 20, the breasts became engorged and, after chilly sensations, the temperature suddenly rose to 104.4 degrees, pulse 140. Although there was slight moisture on the lower part of the wound dressings, there were no signs of wound infection. As the patient lacked the resources for providing care for herself under these conditions, she was sent to the County Hospital, where, under treatment for acute mastitis, the temperature promptly came down. On removal of abdominal and episiotomy sutures, both wounds were found well healed, without infection.

A blood count, showing red blood cells 2,800,000, hemoglobin 43 per cent, on June 16, immediately after operation, and another count on June 24, eight days later—red blood cells 3,800,000, hemoglobin 75 per cent—is a striking demonstration of the recuperative powers of the blood-forming organs, even without the aid of blood transfusion.

COMMENT

In each of the two cases reported by Coleman, both twins were in cephalic presentation. Where one twin is a breech and the other in cephalic presentation, it would seem that danger of locking occurs only when the breech descends before the presenting head, as in the case here reported.

1361 Park Street.

INTERMITTENT CLAUDICATION: THE USE OF TISSUE EXTRACT (PANCREATIC) IN ITS TREATMENT

By ROBERT A. STEVEN, M.D.
San Francisco

THIS report is submitted for the purpose of stimulating greater interest in a form of treatment for arterial disease, particularly of the extremities, which is not used as frequently as it should be. Many excellent reports on the use of certain pancreatic extracts in the treatment of intermittent claudication of the extremities, and of angina pectoris, have appeared since 1929. By far the best results are obtained in intermittent claudication of the legs. Wolffe¹, whose paper includes a complete bibliography, treated twenty-six cases of this disorder, seventeen experiencing complete, and nine partial relief. The following report is that of a patient who had rather a dramatic result.

REPORT OF CASE

M. A., single, Jewish male, age 66, a retired clothing manufacturer, was first seen on December 9, 1935, complaining of pain, of several months' duration, in the left calf. This pain would appear only when walking, and would rapidly disappear with cessation of walking. It had begun insidiously and had been getting progressively worse, with a corresponding diminution in the distance he was able to walk without stopping to rest. When I first saw him he was able to walk only two blocks before the pain forced him to stop and rest for a few seconds, after which he could proceed another two blocks. He was unable to walk grades at all.

He also complained of chronic constipation (nearly all his life), insomnia (sedative every night for years), and hypertension (many years). He never had had any chest pain, dyspnea, or edema. He had stopped the use of tobacco two years previously.

¹ Wolffe, Joseph B.: Further Studies on Tissue Extract No. 568, Tr. Amer. Ther. Soc., 163-169, 1934.

There was nothing else of significance in his history. He had already used the standard treatment of contrast baths, heat, graduated exercises and vasodilators, with little, if any improvement. There was no history nor were there any signs of phlebitis.

Physical Examination.—The heart sounds were hollow. There was slight, if any, cardiac enlargement determinable by physical signs. A₂ P₂. There were no murmurs. The blood pressure was 180/115. Both feet and legs up to the knees were cold to the touch, the left definitely more so than the right. On elevation of the lower limbs above the heart level, both feet and lower legs, but especially the left, rapidly assumed an ashen-white color, while in the dependant position they assumed a very dusky color after one minute. A faint pulsation could be felt in the right dorsalis pedis and post-tibial arteries. No pulsation could be obtained on the left. With the blood-pressure cuff in place at the mid-calf, and inflated between the diastolic and systolic pressures, there was very slight oscillation of the needle when testing the right, and practically no oscillation when testing the left, as compared with a wide swing of the needle on either arm. There were no other significant findings.

I gave him tissue extract No. 568 (Sharp and Dohme) intramuscularly in the deltoid region as follows: 2.5 cubic centimeters on December 11, 18, 26, 30, January 2, 9, 16, 23, and February 10 and 25. Because of the severe local pain, the injections were preceded by novocain the last three times.

COMMENT

On December 16 he walked seven blocks before pain appeared. On December 26 he stated that he could walk as far as he pleased on level ground, but that he had pain when he tried hills. On January 2 he walked one mile without stopping; both legs were warm to the touch down to the ankles. On January 9 he reported a slight return of pain on January 8 and 9. On January 16 he had had no pain all week, although he had walked about town at will. On February 10 and 25 there was no pain at all; he took a trip to the Grand Canyon on February 26, and while there had one hike of three miles, with no pain. On September 14 he reported that he had had no pain since January 9; he walked at will on level ground or slight grades; steep grades gave rise to pain. I have never been able to get any pulsation of the left dorsalis pedis or post-tibial arteries. The last blood-pressure reading, taken on February 10, was 200/110.

384 Post Street.

Surgeon Not Responsible for Error of Nurse.—Attempts are made from time to time to make a surgeon responsible for the error of a nurse or assistant during an operation, but they have failed because it has been held that in the legal sense these persons are not his agents. The most recent case occurred in New Zealand and was due to an unusual cause. A woman claimed damages against a surgeon for injuries received during an operation in a private hospital. The nurse was instructed to paint the patient's skin with iodine, but used a mixture containing phenol (carbolic acid). The New Zealand Court of Appeal, in giving judgment, said that the plaintiff's submission would impose an intolerable burden on the surgeon. Under the conditions of modern surgery it was impossible for the surgeon to do the whole of the work involved in an abdominal operation. He had to work in a team. It was true that he was in complete control, but those subject to him were skilled collaborators with independent duties and there was no delegation of duties in the ordinary sense. He did not intend and could not be taken to have intended to do the work of others in the team. He was not vicariously liable for negligence found against the nurse.—*American Medical Association's London Correspondent.*

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

CHRONIC PROSTATITIS

I. ETIOLOGY AND SYMPTOMS

NATHAN G. HALE, M.D (Medico-Dental Building, Sacramento).—The etiology of chronic prostatitis, in the major portion of the cases treated, is traceable to infection by the Neisserian organism, which, in most instances, has long disappeared from the secretion. The cause of chronic prostatitis, however, is not limited to the gonococcus, and greatest stress should be placed on this fact. Infected teeth, tonsils, and gastro-intestinal abnormalities are not uncommon causes of chronic prostatitis, and in the general examination for these possible foci of infection should not be overlooked.

Trauma in the perineum has resulted in a flare-up of a dormant prostatitis. Infections of the upper urinary tract will also produce this condition. However, in many cases it is difficult to determine whether the prostatitis is the cause of the upper urinary tract infection or, reversely, whether the prostatitis is caused by the infection in the kidney.

There are instances of instrumentation causing prostatitis, and one can say with certainty that prostatitis may become chronic by improper massage of the prostate, or by poor management of an acute infection.

The symptoms may be divided into two groups, the usual and the bizarre. Low back pain is perhaps one of the most common symptoms. Morning urethral drop, particularly following a history of gonorrheal infection, should make one suspicious, and investigation should be made several times before one can be thoroughly convinced that the microscopic picture clearly indicates the condition of the prostate.

Pain in the suprapubic and inguinal regions is not uncommon. Chronic prostatitis and chronic seminal vesiculitis are often associated, and it is difficult to differentiate between the two.

TABLE 1.—*Predominating Symptoms: Analysis of 50 Cases*

Low back pain.....	10
Morning urethral discharge.....	6
Burning on urination.....	6
Frequent urination.....	6
Perineal discomfort.....	4
Rheumatism.....	3
Diminished force of urination.....	3
Pain in the inguinal region.....	3
Pain and redness of eye diagnosed as iritis.....	2
Urgent urination.....	2
Decreased vision diagnosed as thrombosis vein of eye.....	1
Abdominal pain, gastric disturbance.....	1
Urethral discomfort.....	1
Slight terminal hematuria.....	1
Continuous urethral discharge.....	1

TABLE 2

Patients having no history of venereal disease.....	17
Patients having had a history of gonorrhea.....	33
5—"Many years ago"	
1—Thirty years previous to examination	
1—Twenty years previous to examination	
1—Fourteen years previous to examination	
1—Twelve years previous to examination	
1—Eleven years previous to examination	
3—Eight years previous to examination	
1—Seven years previous to examination	
1—Six years previous to examination	
1—Four years previous to examination	
5—Two years previous to examination	
4—Nine months previous to examination	
6—Eight months previous to examination	
2—Six months previous to examination	

The patient may or may not have obstructive urinary symptoms, as they are often contingent upon the involvement of the vesical neck with fibrosis and irritation produced in the posterior urethra.

It must be remembered that the prostate, when it is a foci of infection, is capable of producing symptoms far from the site of infection. Impotency and decrease in erection are not uncommon. However, one should not be so impressed with this fact as to conclude that the treatment of chronic prostatitis will improve all symptoms, without looking to other portions of the anatomy for possible causes of the same symptoms.

Fifty cases of chronic prostatitis collected alphabetically from case histories, either now under treatment or recently treated, are here segregated as to causes and symptoms presented at the time of examination.

In reviewing this small group, several points are presented that tend to prove that the symptoms of chronic prostatitis are bizarre, and that the usual textbook cause of prostatitis, 20 per cent nonvenereal and 80 per cent venereal, may not be correct. In this small group, seventeen cases, or 34 per cent, had no venereal history, and if one notes, fourteen other cases presented could be added to this list in which gonorrhea may have played only a remote part in producing prostatitis. This would bring the total to 64 per cent without a definite venereal background. However, the author believes 64 per cent is too high and 20 per cent is too low.

It is of interest to find that five cases of the fifty presented were harboring in the genital tract the original organism—one case four years after the onset of the infection. No doubt, if a more careful method could be used to search for and to isolate the organism, more cases would have shown the gonococcus.

Three cases of the fifty had eye symptoms. Iritis is more common than is suspected by most

TABLE 3.—*Gonococcus Identified in Cases of Chronic Prostatitis*

1—Four years following onset of infection
1—Two years following onset of infection
1—Nine months following onset of infection
1—Six months following onset of infection
1—Eight months following onset of infection

general practitioners. The case of the thrombosis of a vein of the eye associated with increase in blood pressure bears emphasis, as a careful search was made in this case for all possible foci of infection. Eighty per cent pus was found in the massaged secretion from the prostate, and the patient's condition steadily improved.

Median bars and other pathology of the vesical neck region were found in this group of fifty cases, and no doubt such conditions will be emphasized by other collaborators.

The case with the gastro-intestinal symptoms may not have had a definite relationship to the chronic prostatitis, as the physician's knowledge of the gastro-intestinal tract was not complete. There was, however, a marked prostatitis. Under treatment for this condition the symptoms improved, and the patient could not be convinced that gastro-intestinal series, etc., were necessary at this time.

Stress, then, should be laid on the fact that prostatitis is not always gonorrheal in origin. In a series of fifty unselected cases, 34 per cent were nongonorrheal. One should also stress that, in spite of seeming evidence that symptoms have been produced by the prostate, these symptoms may have been produced by other pathology, and emphasize that even cases diagnosed as chronic prostatitis should have a thorough physical examination.

* * *

II. DIAGNOSIS

ROGER W. BARNES, M. D. (College of Medical Evangelists, Department of Urology, Los Angeles).—The presence of chronic prostatitis is frequently overlooked, and it sometimes produces symptoms attributed to other causes. In the examination of every adult male, care and thoroughness should be used to determine whether or not prostatic disease is present, and especially so when a focus of infection is being sought. Before making the digital examination of the prostate, the patient voids, preferably in two or three glasses, in order to cleanse the urethra of any secretion harbored there. Shreds or cloudiness in these glasses aids in determining the nature and extent of a urethral infection, but does not help in the diagnosis of prostatitis *per se*. After voiding, the patient stoops forward or kneels on a table so that the body is acutely flexed on the thighs, and either he or an assistant holds a glass under the penis to catch the prostatic secretion as it is expressed. The examiner uses the gloved index finger of either the right or the left hand (the same finger should be used each time so as to become accustomed to its use). With a light touch the finger

is slowly moved over the entire surface of the gland and its size, mobility, limitations, and consistency are noted. When chronic infection is present, there are areas of induration which are somewhat harder than normal prostatic tissue, and these can be palpated as small or larger islets with normal prostatic tissue between. If the infection is extensive, the entire gland may be indurated and somewhat fixed, or if periprostatitis is present the hardness extends beyond the limits of the prostate. This type is occasionally mistaken for prostatic malignancy, but the latter is usually more stony-hard and more fixed. If the chronic inflammation in the prostate has been of long standing, fibrosis may dominate the picture. In this case rectal palpation reveals a gland which is somewhat smaller than average, quite "tough," but not stony-hard, and quite movable and well defined. A prostate which is quite symmetrically enlarged, tense and tender, feeling like a tightly stretched skin over an area of acute cellulitis, is acutely inflamed, and should not be massaged under any circumstances.

A form of chronic prostatitis without infection exists. As palpated through the anterior rectal wall, this type of gland is somewhat larger than average, well defined, soft, boggy, and sometimes "pits" on pressure. It is sometimes designated as chronic congestion of the prostate, or "toxic hyperplasia," and from it 0.5 cubic centimeter to 2.0 cubic centimeters of prostatic secretion can be expressed by proper massage. Even though this secretion shows no pus or other evidence of infection, it causes symptoms which are relieved by massage and proper sex hygiene.

In some cases a definite diagnosis of chronic prostatitis can be made by rectal palpation; nevertheless an examination of the prostatic secretion is essential either to confirm or to make a diagnosis. If the prostate is massaged properly, it is very seldom that this cannot be obtained. The ball of the finger is placed as high as can be reached on one side of the prostate, and with gentle pressure it is slowly moved downward and medially, following its lateral margin until the apex in the midline is reached. This stroke is repeated three or four times, each time starting a little nearer the midline. After one side is massaged in this manner, the same procedure is repeated on the other side, and lastly two or three gentle downward strokes in the midline are given. This will almost always express a few drops of secretion, which are placed on a slide, covered with a cover glass, and examined under first the low, then the high, dry power of the microscope. If more than one or two leukocytes are seen in a high, dry field, a diagnosis of chronic prostatitis can be made. A convenient method of designating the amount of pus present is to estimate the approximate per cent of the entire field covered with leukocytes and record it in this way—2 per cent, 20 per cent, 80 per cent, etc. Granular prostatic epithelial cells are sometimes difficult to distinguish from pus cells, especially mononuclear leukocytes, and a Gram stain of the dried smear is necessary to determine the amount of pus. Such a stained

smear will also reveal bacteria if many are present. If facilities are available for making bacterial cultures, these should be used in diagnosing infection in the prostate, for, by it more accuracy can be attained both in diagnosis and treatment. However, for the general practitioner to whom these facilities are not available, the microscopic examination of the freshly obtained prostatic secretion is sufficient. Occasionally a case may present findings by rectal palpation which are suggestive of chronic prostatitis, but no pus is found in the prostatic secretion. This may be because the infection is deep in the gland and the massage did not express the secretion from the infected alveoli. In such cases the massage is repeated every three or four days until pus is found, or until prostatic infection has been definitely eliminated.

Endoscopic examination of the prostatic urethra may aid in diagnosing chronic prostatitis, but is not essential to such a diagnosis. When this is done it is found that the mucous membrane of the prostatic urethra is fibrotic in character, being lighter in color than normal, and retracted. The prostatic duct orifices are dilated and rigid, and frequently pus can be seen to ooze from these. If fibrosis is extensive, the bladder neck is contracted and rigid, and often thickened as palpated between the cystoscope and the examining finger in the rectum.

For the general practitioner, however, digital examination of the prostate, and examination of the freshly expressed secretion under the high dry power of the microscope is sufficient to make a diagnosis of chronic prostatitis.

* * *

III. TREATMENT

FRANCIS H. REDEWILL, M. D. (870 Market Street, San Francisco).—We have to believe with Paul Broca, who said, "I'd rather be a well-developed ape than a degenerated Adam," when we physicians continually come in contact with male patients, in all walks of life from laborers to undertakers, from clerks to dentists, from plumbers to philanthropists, who report to us that from five to thirty years or more they have been seeking merely relief from chronic prostatitis. As involved as are the prostates of these individuals—pathologically speaking—with proper urological treatment, over 95 per cent of them can become clinically cured. Yet, to effect a cure may test the skill of the best trained specialists in the genito-urinary field.

Needless to say that the patients with chronic prostatitis must have a complete physical examination. On the one hand, the general examination may reveal foci of infection in other parts of the body that may have to be cleared up before the prostate can be cured. On the other hand, the whole urinary tract should often be studied to determine and attempt to eradicate any pathology in way of obstruction and infection from the kidneys to the meatus before or during the treatment of the prostate, because other parts of the urinary

and sexual apparatus are so intimately connected to that gland that, with untreated pathology in the former, it may be impossible to cure the latter. Besides having these focal infections in any part of the body, including the genito-urinary tract, the patient with chronic prostatitis may be run down and generally debilitated from excesses, overwork, lack of rest, worry, and improper diet—any of which conditions will have a tendency to impede the curative treatment of the prostate. It often becomes the duty of the practitioner to give advice that may radically change the patient's mode of living together with prescriptions for tonics, sedatives, and diet lists containing generous amounts of vitamins. Thus, we must often consider the patient's entire physical condition, rather than confine our attention solely to the genital tract, in successfully treating prostate cases.

An outline of chronic prostatitis treatment may be made more comprehensible if we divide the pathologic conditions of this gland into two classes, namely, (1) chronic prostatitis without morbid structural changes in the posterior urethra or vesicle neck, (2) those in which there are visible pathologic changes in the way of dilated ducts, sinuses, crypts and contractures of the neck, or stones.

The one prerequisite factor to effect a cure in chronic prostatitis is to establish efficient drainage. The only method of establishing drainage is by way of the forty-odd ducts leading from the prostate into the prostatic urethra; the obstruction in the minute ramifications of these ducts must be opened up, and the universal practice of accomplishing this is by means of prostatic massage. The force, intensity, and duration of each prostatic massage is determined entirely by the pathologic condition of each individual prostate. The general rule to follow is that better results are obtained by massaging gently for a period four times as long rather than to massage forcibly for ten to thirty seconds. There is a reflex sympathetic nerve response in those who have never had a prostatic massage, so that, if one gives the first massage very forcibly, it may place the patient in deep surgical shock, and even deaths have been reported from such indiscreet procedure. Also such harsh preliminary treatment may induce the rapid formation of prostatic abscesses and epididymitis that are very painful and incapacitating. Therefore, the rule is, "Go slowly, and feel your way." Following massage, through and through irrigation is in order. Such solutions as potassium permanganate 1-4000, warmed to about 100 degrees Fahrenheit, or weak mercurials such as metaphen methiolate or mercurochrome and acriflavine in 1-1000, are very efficient. If there is a concomitant irritating cystitis, especially in elderly feeble men, a boric acid 2 to 4 per cent solution, with distilled water, is the most soothing irrigation to use following massage. Because, at least, a mild chronic cystitis and posterior urethritis often exist in these prostate cases, most urologists usually inject into the emptied bladder, following irrigation, a mild silver salt such as

5 per cent silvol. However, with a more intense involvement of the prostatic urethra, such as a verumontanitis, stronger antiseptics should be applied topically, with a Keys syringe or soft rubber catheter. Four cubic centimeters of 1 per cent acriflavine can be locally applied. Also astringents are often required, of which silver nitrate from one-half to 4 per cent is very extensively used. Antiseptic astringent that is very efficient is made of the following formula:

Zinc sulphatis	0.25
Liq. plumbi subacetatis dil.	100.00

With verumontanitis associated with chronic prostatitis, gratifying results, following massage, are often obtained with a dehydrating agent such as 5 per cent sulphonated bitumen in glycerin; inject the posterior urethra with a Gunyon or ordinary soft rubber catheter. When using these stronger injections, it is far more comforting to the patient, for the first few treatments, to precede such injections with topical application of a few cubic centimeters of 2 per cent novocain.

It is generally agreed by many leading authorities that when stripping of the prostate continues to yield pus, heat applied to the pelvis and more particularly to the prostate through the rectum is indicated, thereby increasing the circulation and aiding the tissues to put up a fight against the infection. It is puzzling doctors today to know whether to use diathermy, short-wave, or ultra-short-wave heat in these cases. It is generally recognized now that both diathermy and short-wave have their respective fields of usefulness and, contrary to what was predicted more than a year ago, we cannot replace diathermy with short-wave. Undoubtedly, diathermy is by far the best modality for continued treatment of the prostate through the rectal walls. For more diffuse heat through the pelvis, bipolar short-wave can be used or monopolar ultra-short-wave magnetic coil can be placed above the lower abdomen and apply heat with the inductotherm. Heat applied by any of these methods should be given for periods of thirty to forty-five minutes from two to three times a week.

While chronic prostatitis disturbance—which is understood as prostatism—seems to occur more in persons who do not present a history of gonorrhea, it is to be kept in mind that prostatitis is a frequent complication of acute gonorrhea, it being held probably true by many leading authorities that there are few cases of male gonorrhea in which the prostate is not involved to a more or less serious degree. When the gonorrheal infection has become established in the prostate, it is soon complicated by secondary bacteria, usually the staphylococcus, but less often by the colon bacillus, streptococcus, enterococcus, and pseudodiphtheroid bacillus. The infectious factor justifies deliberate attempt at immunization, in which vaccines—especially autogenous vaccines—come into consideration. Then, also, nonspecific protein therapy with milk, typhoid vaccine, proteolac, omnadin, activin, edwenil, and similar preparations, may be used to stimulate leukocytic activity,

and thereby build up increased bodily resistance to various types of prostatic infection. There is also chemotherapy, as suggested by a host of authors which, like vaccinothrapy, and foreign proteid therapy, aims to overcome the infection through utilizing powers of the patient himself by increasing his resistance. The stimulation of the antibacterial powers include an increase in the ability of the phagocytes to remove the products of infection, and, of course, the white blood cells are a means to that end. Hence, any leukocytic stimulant may prove of value.

Two classes of patients with chronic prostatitis that are the "bugbear" of physicians are the sexual neurasthenics that have been rendered neurotic by years of prostatic massage without obtaining relief, and the so-called "gleet" cases in which there is a more or less continuous discharge from the urethra. These sorts of cases that have had all kinds of routine treatment mentioned above, without receiving permanent benefit, may complain of definite perineal pain, aching, throbbing, or perirectal discomfort. Some have dysuria of varying degrees; some have definite histories of recurring acute prostatic abscess; most of them have chronic urethral discharge, many of them, especially of the neurasthenic type, have metastatic symptoms such as lumbar pain, sciatic neuritis, and pain in the sacro-iliac or other joints, sometimes with acute synovitis. The chronicity of these cases may be realized when it has been reported by several authors that the average duration of symptoms extend over a period of seven years, and the trouble may have existed as long as thirty years.

Endoscopic, or better, cystoscopic studies should be made, at least of all chronic prostatic cases of long standing. With such thorough examination it will be found that these more chronic types exhibit a more extensive pathology with such condition as median bar at the internal sphincter, which is generally believed to be irritated and stimulated to hypertrophy by chronic infection at the vesicle neck. Also, there may be minute subacute abscesses of the prostate and there may even be diverticula of the prostatic ducts with very small openings from these diverticula leading from the prostate to the urethra. Urethrograms have demonstrated relatively large pockets draining into the urethra through narrow ducts. Then such dilated ducts filled with prostatic calculi may be numerous. These classes of cases come under the second group mentioned in the first part of this paper, and to obtain permanent relief must be submitted to minor surgical procedures. Fulguration and electric coagulation will correct local urethral pathology. The deeper pathologic processes should be subjected to electrocautery, with free openings of the abscesses and ducts, removing of the calculi, and even removal of median bar and considerable prostatic tissue to establish free drainage of prostatic ducts on the one hand, and the free drainage of the bladder on the other. Such surgery will clear up and cure, along with routine treatment, over 95 per cent of all intractable, old chronically infected prostates.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *House of Delegates Minutes.*
2. *Council Minutes.*
3. *Executive Committee Minutes.*
4. *Health Insurance Legislation.*
5. *Sixty-Sixth Annual Session.*
6. *Del Monte Scientific Program.*
7. *Enemies.*
8. *Annual Meeting—Bystander Comments.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Chairman.*
2. *Proposed Activities.*
3. *Medical Legal Services.*
4. *To Be a Funeral Director.*
5. *Group Hospitalization.*

ASSOCIATION ACTIVITIES

HOUSE OF DELEGATES MINUTES

Minutes of the Sixty-Sixth Annual Session of the House of Delegates of the California Medical Association

Held at Del Monte, California, Monday, May 3, 1937, and Wednesday, May 5, 1937

Foreword.—By action of the House of Delegates the official minutes of the House of Delegates, as electrically transcribed during the two meetings of this session, were ordered abstracted by the Speaker, the Chairman of the Council, and the Secretary, and published in abbreviated form in CALIFORNIA AND WESTERN MEDICINE. The official and complete minutes, with all discussions upon the various questions considered by the House of Delegates are on file in the office of the Association and are open for inspection, consultation, and reference to any officer, delegate, or member of the Association.

The following, therefore, is an abbreviated transcript of those minutes. (Signed) WILLIAM W. ROBLEE,

Speaker of the House of Delegates.

MORTON R. GIBBONS,

Chairman of the Council.

F. C. WARNSHUIS,

Secretary of the Association.

* * *

FIRST MEETING

Monday, May 3, 1937

1. **Call to Order.**—The opening session of the House of Delegates of the California Medical Association was called to order by Speaker William W. Roblee of Riverside, in the Auditorium of Hotel Del Monte, Del Monte, California, at 8:30 p. m., Monday, May 3, 1937.

2. **Personnel and Report of Credentials Committee.**—The Speaker announced the appointment of the following

*All articles listed under the caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

Committee on Credentials: Stanley Mentzer of San Francisco (chairman), Walter F. Wessels of Los Angeles, and S. J. McClendon of San Diego. Chairman Mentzer reported 103 delegates accounted for and ready to be seated, and there being no objection the Chair ordered the approved delegates seated for this meeting.

ROLL CALL

First Session of the House of Delegates, Sixty-Sixth Annual Meeting, Del Monte, May 3, 1937

Alameda County

A. A. Alexander
D. M. Allen
C. A. Dukes (officer)
E. N. Ewer
T. C. Lawson
H. G. MacLean
F. R. Makinson
George Reinle
H. J. Snook

Fresno County

C. H. Ingram
Henry Randel
G. W. Walker

Kings County

P. K. Edmunds

Los Angeles County

E. Vincent Askey
John V. Barrow
H. L. Charles
Fred B. Clarke
John W. Crosson
W. H. Daniel
Edward B. Dewey
Alvin G. Foord
P. A. Gallant
Lowell S. Goin
V. J. Keating
G. H. Kress (officer)
E. Eric Larson
W. H. Leake
Orville N. Meland
William R. Molony
E. E. Moody
John W. Nevius
J. P. Nuttall
James F. Percy
C. E. Phillips
F. M. Pottenger, Sr.
F. M. Pottenger, Jr.
H. A. Putnam
E. T. Remmen
John C. Ruddock
V. De Mott Sedgwick
Philip Stephens
W. Wessels
Howard F. West
Harry Wiley

Marin County

C. W. Clark

Orange County

Dexter R. Ball
G. Wendell Olson
L. F. Whittaker

Riverside County

Bon O. Adams
A. L. Bramkamp

Sacramento County

Paul H. Guttman
Frank A. MacDonald
F. N. Scatena

San Benito County

Robert S. Geen

San Bernardino County

C. L. Emmons (Councillor)
Harold G. Gentry
Ray M. Moose
A. L. Weber

San Diego County

A. J. Cooper
William L. Garth
Hall G. Holder
S. J. McClendon
C. O. Tanner (Councillor)
P. E. Toomey

San Mateo County

J. Garwood Bridgman

San Francisco County

Elbridge J. Best
Zera Bolin
Edwin L. Bruck
L. R. Chandler
John W. Cline
L. H. Garland
Thomas E. Gibson
P. K. Gilman
Irving S. Ingber
A. R. Kilgore
Stanley H. Mentzer
Howard Morrow
Roland P. Seitz
W. F. Swett
D. A. Wood

Santa Barbara County

W. H. Eaton
H. E. Henderson
H. J. Ullmann (Councillor)
Irving Willis

Santa Clara County

C. M. Burchfiel
C. Kelly Canelo
Russel V. Lee
R. S. Kneeshaw

Santa Cruz County

F. E. Blaisdell, Jr.

San Joaquin County

Dewey R. Powell
George H. Sanderson

Shasta County

G. L. Kay

Solano County

John W. Green

Sonoma County

C. B. Andrews
Leonard W. Hines

Stanislaus County

R. S. Hiatt

Tulare County

J. C. McClure

Ventura County

A. A. Morrison

Yuba-Sutter County

Francis R. Wisner

Yolo-Colusa-Glenn County

Charles S. Roller

Mendocino-Lake County

R. A. Cushman

Merced County

E. A. Jackson

Monterey County

James H. McPharlin
Mast Wolfson

3. Personnel of Reference Committee No. 1—Reports of Officers and Standing Committees; and Reference Committee No. 2 Resolutions and New and Miscellaneous Business.—The Speaker announced the appointment of Fred N. Scatena of Sacramento (chairman), Louis A. Packard of Bakersfield, and John P. Nuttall of Los Angeles, as Reference Committee No. 1.

And Lowell S. Goin of Los Angeles (chairman), E. J. Best of San Francisco, and Henry J. Ullmann of Santa Barbara, as Reference Committee No. 2.

4. Address of President Edward M. Pallette.—President Edward M. Pallette addressed the delegates in the customary manner, supplementing his printed address published in the Pre-Convention Bulletin.

5. Presentation of Gavels to Past Speaker.—William H. Kiger, Councilor-at-Large from Los Angeles, presented to President Pallette a redwood gavel as a token of appreciation for the services he had rendered as Speaker of the House of Delegates for a period of six years, from 1929 to 1935.

Past President Robert A. Peers of Colfax presented to Speaker William Wallace Roblee of Riverside a redwood gavel suitably engraved as a token of appreciation for his services as Speaker of the House during the sessions of 1936 and 1937.

President Pallette and Speaker Roblee made very gracious responses to these presentations.

6. Presentation of Certificates to Past Presidents.—By action of the Council, suitable certificates were presented to all living past presidents of the Association, reading as follows: "The California Medical Association confers this certificate upon Past President . . . At the conclusion of his term as president of the California Medical Association during the Association year of . . . Recognition is given to the services rendered by him and the contributions he has made to this Association, to public health welfare, and to the advancement of medical science and practice. Presented this third day of May by the authority and action of the House of Delegates of the California Medical Association." Signed by the Chairman of the Council, the Speaker of the House, and the Secretary.

Speaker Roblee in a very dignified manner conferred these certificates upon Doctors George Evans (president in 1907), San Francisco; John C. King (1910), Pasadena; O. D. Hamlin (1912), Oakland; George H. Kress (1916), Los Angeles; John H. Graves (1921), San Francisco; Edward N. Ewer (1925), Oakland; William H. Kiger (1928), Los Angeles; Morton R. Gibbons (1929), San Francisco; Lyell C. Kinney (1930), San Diego; Junius B. Harris (1931), Sacramento; Joseph M. King (1932), Los Angeles; George G. Reinle (1933), Oakland; Clarence G. Toland (1934), Los Angeles; Robert A. Peers (1935), Colfax.

7. Tribute of Alameda Members to Councilor O. D. Hamlin.—George G. Reinle, representing the Alameda members, presented a very beautiful lamp and desk set to Councilor O. D. Hamlin in appreciation of his services and also as a testimonial and memorial of his term as president of the Association, to which office he was elected twenty-five years ago at Del Monte, in 1912.

8. Presentation of President of National Woman's Auxiliary.—Under instruction of Speaker Roblee, the Secretary escorted Mrs. Robert E. Fitzgerald of Wauwatosa, Wisconsin, President of the National Woman's Auxiliary, to the platform. President Fitzgerald responded as follows:

It is indeed a great pleasure for me to be with you. Many years of experience have taught me that a woman, like a child, should be seen and not heard, and so I shall take this opportunity merely to thank the men of California for the wonderful cooperation they have shown the Auxiliary of this State and to thank you all for the great courtesy that you have extended to me this evening. I do thank you.

9. Report of the Council.—Morton R. Gibbons, Chairman of the Council, presented the following as the Council's report to the House of Delegates:

REPORT OF THE CALIFORNIA MEDICAL ASSOCIATION COUNCIL

This is the 1937 report of the Council to the Speaker and the House of Delegates. This annual report of the Council is hereby presented to you and through you to the members

of the Association. CALIFORNIA AND WESTERN MEDICINE has published the full minutes of all the meetings of the Council or digested Executive Committee meetings. Such publications form part of this report. This annual report is limited to summarization, comment, and emphasis on such subjects as your Council feels should receive special consideration by the House of Delegates and membership. As an appendix to this report there will be found the statement and comments of the Association's certified public accountant. The Council submits this without further comment.

Annual Dues.—The Council recommends that the House of Delegates fix the annual dues for 1938 at \$10.

The annual report of the Secretary shows a total of 5,567 members. There were 397 new members for 1936. The Secretary-Treasurer's report analyzes the subject of membership in several ways, and a careful scrutiny and consideration of its revelations are of value. You are again reminded that approximately 20 per cent of the desirable and eligible members of the profession are not members of this Association.

Council Meetings.—During the year the Council has held six meetings, besides one emergency meeting on two days' notice, attended by all councilors, to consider legislative matters. The Executive Committee has held three meetings. Many members of the Council attended the conference of county secretaries.

The reports of councilors are printed in the Pre-Convention Bulletin. They disclose the individual experiences and problems of the various councilor districts.

Great impetus has been given to the Association's activities and county units' contact therewith by the self-sacrificing work of President Pallette and his immediate predecessors, who, accompanied by the Secretary-Treasurer, visited and met with practically every county unit. We should pause a moment to realize what such devotion entails.

Appeals.—The Judicial Council of the American Medical Association has acted upon the following appeals: On April 5, 1937, the Judicial Council, finding no reversible error or injustice in the case, sustained the decision of the Council of this Association in the matters of the appeals of Doctors F. W. Callison, J. L. McClure, Harry W. Davis, George J. Heppner, James F. Pressley, Frank E. Stiles, Edward Melville Talbott, Bertram Stone, Louis Clive Jacobs, and Herbert J. Cohn.

The Judicial Council has also sustained the decision of the Council of this Association, affirming, in part, orders entered by the Kern County Medical Society against Doctors Joe K. Smith, John M. Kirby, and R. M. Jones.

Scientific Sections.—A special committee which reported last year suggested a plan for consolidation of scientific sections. Section officers will report at this session of the House of Delegates. Careful study and consideration of this report is recommended. The Council makes no further recommendation in this matter.

County Hospitals.—County hospital legislation is still pending. It is a serious question and may become one upon which the people will have to vote. Therefore, you should listen carefully to the report of the Legislative Committee.

Hospital Insurance.—The Committee on Public Relations will discuss this subject. The Council is fully cognizant of and in intimate contact with all matters pertaining to this subject and stands ready to act in any contingency which may arise.

Health Insurance.—The Committee of Five will report upon the present status of this subject. You should be informed that the California Medical Association has worked in close accord with the California State Board of Health and is using every effort to bring about the publication of the report by the end of the present fiscal year.

Legislation.—The Committee on Public Policy and Legislation will make a report. It is not necessary here to comment upon the subject matter. In listening to the Committee's report, the members of the Association should appreciate the tremendously valuable and unique service which the members of the Committee have rendered to the cause of public health and to every member of this Association and to the medical profession. Such service has entailed sacrifice for which no one should ask and for which no compensation would be adequate. The greatest thanks and admiration of which we are capable are inadequate.

The American Medical Association Meeting for 1938.—Doctor West, Secretary of the American Medical Association, and Doctor Sleyster, Chairman of the Trustees of the American Medical Association, made a recent visit to San Francisco, and were entertained at dinner by Association members around the Bay. They gave a hopeful prognosis. It will be well to instruct the delegates to the American Medical Association to use every honorable means to procure the selection of San Francisco for the 1938 American Medical Association convention.

COUNCIL RESOLUTIONS

Governmental Health Activities.—The Council submits and recommends the adoption of the following resolution:

Resolution on Federal Health Activities. (See p. 421)

Doctor Gibbons then presented another resolution on behalf of the Council:

Resolution Concerning Procedure in Admission of New Members. (See p. 422)

Doctor Gibbons then presented another resolution introduced by the Council:

Resolution for an Additional Reference Committee at Annual Sessions. (See p. 422)

In Conclusion.—Finally, it should be reported that the members of the Council and Executive Committee have attended meetings with truly remarkable regularity and maintained wonderful enthusiasm, often in spite of great personal inconvenience and sacrifice. Our Secretary-Treasurer and his staff are most efficient and indefatigable. Our Editor has produced a journal better than ever and second to none, and has been more intimately conversant with Association affairs than any other individual. Our General Counsel and his associates have been ever on the alert for our interests, most responsive and cooperative. To them all we owe generous appreciation and thanks.

(Signed) THE COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION.

M. R. Gibbons, *Chairman.*

The Speaker referred the resolutions presented by the Council to Reference Committee No. 2. The remainder of the report of the Council was referred to Reference Committee No. 1.

10. Report of The Trustees Of The California Medical Association.—Morton R. Gibbons, President of the Trustees Of The California Medical Association, presented a financial report on the Trustees stating that they had a reserve fund of \$52,719.70.

The Speaker referred the report to Reference Committee No. 1.

11. Report of the Auditing Committee.—Karl L. Schaupp, Chairman of the Auditing Committee, submitted the following report:

You will notice the report of the Auditing Committee is on the budget. That is, there is a change in the set-up we have had in previous years. Each year a certain amount of money was allocated to departments, which was charged against these departments for their operations. This year, under the set-up of the auditors, there is a new form in which, this being a nonprofit organization, we have only two listings: one, that of the estimated income; and the other, that of the estimated expenditure. The estimated income for the incoming year, 1937-1938, is:

Dues, at \$10.....	\$56,000.00
Advertising sales (advertising in the Journal).....	27,500.00
Subscriptions to the Journal.....	250.00
Reprint sales.....	1,000.00
Interest.....	80.00
Commercial exhibits.....	5,000.00
Miscellaneous.....	3,000.00
Addressograph service.....	100.00
Total.....	\$92,930.00

There is one thing we wish to call your attention to in this estimated income and that is, the commercial exhibits. At the present time the income from the exhibits is such that the convention is not only paid for, but makes a profit.

Also, subscriptions to the JOURNAL in the amount of \$250 do not mean the subscriptions of the members, but copies actually sold through the office.

That takes care of the estimated income. Appropriations from this amount would be as follows:

ESTIMATED EXPENSES

Rent.....	\$ 3,288.00
Estimated telephone and telegraph.....	500.00
Postage for the Association.....	750.00
Stationery and printing.....	1,000.00
Office supplies.....	500.00
Clerical salaries.....	8,175.00
Secretary-Treasurer-Director.....	12,000.00
Travel expense of officers.....	200.00
Travel expense of the Council.....	1,000.00
Executive Committee.....	400.00
Travel expense of the Secretary.....	1,000.00
American Medical Association delegates.....	1,500.00
Department of Public Relations.....	4,000.00

Council and general expense.....	250.00
Postgraduate instruction.....	2,000.00
Committees' expense.....	1,000.00
Annual meeting.....	1,000.00
Legislation and public relations.....	3,000.00
Legal Counsel.....	4,000.00
Extra legal services.....	1,000.00
Legal costs.....	4,000.00
Sundry expenses.....	200.00
For the libraries.....	3,500.00
Printing California and Western Medicine.....	25,000.00
Editor's expense and postage.....	300.00
Mailing of the Journal.....	750.00
Advertising commissions.....	4,000.00
Discounts.....	500.00
Editor's salary.....	4,000.00
Journal supplies.....	300.00
Cuts for illustrations.....	500.00
Addressograph service.....	75.00
Copyrights.....	24.00
Reprint costs.....	600.00
Committee of Five.....	2,500.00
Unexpended balance.....	3,618.00
Total.....	\$92,930.00

In explanation of travel expense, when the officers of the Association travel or the Council travels, there is reimbursement for railroad fare and Pullman, but none of the other expenses. In the matter of the American Medical Association delegates, the expenses vary from year to year because of the location of the American Medical Association convention.

There is another thing to note in regard to this, that this is estimated. There are certain items for which we are sure the expenditure will not equal the estimated appropriation, so that at the end of the year the unexpended balance will be quite in excess of the estimated unexpended income.

The Chairman of the Auditing Committee recommends that the report be adopted.

(Signed) THE AUDITING COMMITTEE.

By Karl L. Schaupp, *Chairman.*

The Speaker referred the report of the Auditing Committee to Reference Committee No. 1.

12. Reports of Officers, Standing and Special Committees.—The reports of the Secretary-Treasurer, Editor, General Counsel, and the Councilors and Standing and Special Committees, as printed in the Pre-Convention Bulletin, were referred by the Speaker to Reference Committee No. 1.

13. Report of Committee on Public Policy and Legislation.—Junius B. Harris, Chairman of the Committee on Public Policy and Legislation, submitted the following report:

With the opening of the Legislature, our first concern was the personnel of the committees which would consider public health legislation. Both Lieutenant-Governor George J. Hatfield and Speaker of the Assembly, William Moseley Jones, were very cooperative, and as a result the committees appointed are very fair-minded.

To date, 4,185 proposed laws have been introduced—an all-time record for California. We have scanned all of these bills and find over 250 have some reference to the practice of the medical professions and public health legislation. We are concerned with fifty-four committees, which meet from 8:30 in the morning until the wee sma' hours of the following morning, to say nothing of the actual sessions of the Assembly and the Senate, where measures of concern to us pop up for a vote almost every day. Subdivided by groups, we find the following:

Board of Health.—Fifteen bills were introduced relating to the powers of the State Board of Health. Representatives of the department are watching this legislation carefully.

Chiropody.—The chiropodists are sponsoring two bills to regulate misleading advertising. These have passed the Assembly and are now before the Senate.

Chiropractors.—The chiropractors have been on the job in force, as usual, trying to extend their rights through two bills. To date, both of these are buried in committee.

Clinical Laboratories.—The lay laboratories reintroduced their bill, which was passed in 1935, but found unconstitutional. It has passed the Senate and is now before the Assembly.

Code Bills.—During the last two years the California Code Commission has been busy codifying the existing laws relating to the business and professional acts of the State. These are known as the Dental Code, Medical Code, Optometry Code, etc. These bills have passed the Senate and the Assembly and are now before the Governor for consideration.

Compensation Act.—Several bills were introduced by persons who have sought to amend the Compensation Act. Two of these were the medical and hospital-records bills, requiring records to be exhibited to the patient and any person he authorizes to examine the same. Seven others would give the injured employee free choice of healer (not confined to M. D.'s). To date, none of these bills and nothing vitally concerning the Compensation Act have been passed.

County Hospitals.—One of the hottest fights has been against three bills and a proposed constitutional amendment which would open up county hospitals to so-called "pay patients." These bills have had powerful backing from the Farm Bureau, from labor and from various boards of county supervisors, and it has only been through the united work of the California Medical Association, the Public Health League of California, the Hospital Associations, and the State Dental Associations that they have been held in check. One of them was tabled in committee; two others have failed to muster sufficient votes to emerge from committee, and the constitutional amendment has been sent back to committee.

Expert Testimony.—Senate Bill 446, sponsored by the California Medical Association, has passed the Senate and is now in the Assembly.

Health Insurance.—The toughest battle to date has been on the subject of health insurance. Two bills were introduced early in the session—one in the Senate and one in the Assembly—to set up control of voluntary health service associations in the Department of Insurance. These "companion" bills were sponsored by interested medical "groups" in Los Angeles and San Francisco. They enlisted the support of the Farm Bureau and large groups of public employees, teachers, etc., who are subscribers to one or the other service. The Farm Bureau has made this one of its major objectives, its representative apparently giving more time to trying to regulate the medical and dental service than to promoting strictly farm problems. This subject has been constantly before the Assembly Committee on Insurance since March 26. To meet an apparent demand for legislation enabling voluntary medical service insurance, the California Medical Association sponsored two bills on this subject (Senate Bill 605 and Assembly Bill 1491). Such strong objection was rendered from various sources that Assembly Bill 1491 was amended in many of its provisions, and is now before the Assembly for vote.

On May 10, the supporters of Assembly Bill 1283 (sponsored by the above-named groups) brought it before the Assembly for vote. It received twenty-four favorable votes and forty-six in opposition!

Hospitalization Insurance.—The Association of California Hospitals is sponsoring Assembly Bill 1132, designed to set up machinery for the sale of hospital service on an insurance and nonprofit basis. This has passed the Assembly, and is now before the Senate for vote.

Medical Practice Act.—Thirty-three bills proposing to amend the Medical Practice Act are before the Legislature, only seven of which were sponsored by the Board of Medical Examiners. The remainder are from outsiders who seek to dress up the Act according to their special ideas.

Naturopaths.—Developing unexpected strength, and with a well-financed organization, the naturopaths have carried on a hot campaign to enact Assembly Bill 1472, which is almost identical with the old Proposition 17 which was defeated in 1934 as an initiative. The bill was defeated in the Assembly, 16 to 49.

Optometry.—The optometrists brought up a proposal to amend their Act so as to permit them to treat eyes. When the battle was over, the "treatment" provision had been deleted.

Osteopaths.—The osteopaths have been more active and more determined at this session than ever before. They have combed every bill before the Legislature and, wherever possible, have proposed seemingly harmless amendments to present themselves to the public on the same basis as Doctors of Medicine.

X-Ray.—Assembly Bill 1009, sponsored by the Pacific Roentgen Club, was introduced on January 20, but to date it has not been taken up by the committee for hearing.

The Speaker referred the report of the Committee on Public Policy and Legislation to Reference Committee No. 1.

13. Report of the Committee on Venereal Diseases.—Howard Morrow, Chairman of the Committee on Venereal Diseases, requested the privilege of presenting this report at the Wednesday meeting of the House of Delegates, and there being no objection the Speaker so ruled.

14. Report of Committee on Relation of Trauma to Malignancy.—Charles A. Dukes, Chairman of the Cancer Commission and of the Special Committee to which the

resolution on relation of trauma to malignancy adopted at Coronado was referred, stated that the question was of such import that the Committee requested an extension of time. There being no objection, the Speaker stated that the House accorded to the request.

15. Report of Committee on Practice of Radiology and Pathology in Hospitals.—Charles A. Dukes, Chairman of the Special Committee on Practice of Radiology and Pathology in Hospitals, submitted a resolution. (See p. 419.)

The Speaker referred the report on practice of radiology and pathology in hospitals to Reference Committee No. 1.

16. Report of the Committee of Five.—The report of the Committee of Five, as published in the Pre-Convention Bulletin (Supplement, April issue, page 153), was referred by the Speaker to Reference Committee No. 1. (See p. 425.)

17. Introduction of Resolutions.†

(a) Public Health Education and Educational Films. Introduced by Dr. Fred B. Clarke of Long Beach. (See p. 420.)

* * *

The Speaker referred resolution (a) to Reference Committee No. 2.

* * *

(b) Annual Conference of Standing Committees. Introduced by Dr. John V. Barrow of Los Angeles. (See p. 417.)

* * *

Speaker Roblee referred the resolution to Reference Committee No. 1 for action, since this resolution overlapped the recommendations contained in the Secretary's report.

* * *

(c) Physicians' Listings in Classified Section of Telephone Directories. Introduced by Dr. Dewey R. Powell of Stockton. (See p. 422.)

* * *

Speaker Roblee referred the resolution to Reference Committee No. 2.

* * *

(d) Amendment to Constitution, Article VII, Section 1—Election of Councilors. Introduced by Dr. Loren R. Chandler of San Francisco.

(d) Resolution Regarding Nomination and Election of District Councilors

RESOLVED, That Section 1 of Article VII of the Constitution of this Association be and hereby is amended as follows, by striking out all of the third paragraph of said Section 1 of Article VII, reading as follows:

"The nine district councilors shall be elected as follows: Prior to the time set for the election of district councilors the delegates of each councilor district for which a councilorship is about to become vacant, shall meet, organize, and in due form elect one or more members of the said councilor district as the nominee or nominees for the said vacancy. Such nomination or nominations shall be submitted in writing, signed by at least two delegates who were present at such meeting, and shall be given to the Secretary-Treasurer, by him to be transmitted to the House of Delegates. The House of Delegates may make additional nominations from the floor of the House, and in the event that the delegates from a councilor district fail to submit a nomination or nominations, shall on its own account proceed to make nominations for each district councilor vacancy. A vote shall then be taken by the House of Delegates to determine who shall be elected to the vacant councilorship"; and by inserting in lieu thereof the following:

The nine district councilors shall be elected as follows: At least one month prior to the time set for the election of district councilors, the Secretary-Treasurer shall mail a written notice to each delegate, addressed to his address listed in the Association's records, of each councilor district for which a councilorship is about to become vacant, notifying the delegates of the time, which must be at least two weeks after the mailing of the notices, and a place designated by the Secretary-Treasurer, for the nomination meeting of the delegates of said councilor district.

†Editor's Note.—For convenience of reference, the original resolutions as introduced at the first meeting of the House of Delegates, appear in the Reference Committee reports as presented at the Wednesday evening meeting, in order that the action taken by the House thereon may be more easily appreciated.

At the time and place designated in said written notice, delegates shall meet, organize and elect by a majority vote a member of the said councilor district as nominee for district councilor for such councilor district for the ensuing term. The delegates shall then transmit in writing to the Secretary-Treasurer the result of such nomination meeting, and the Secretary-Treasurer shall report the same to the House of Delegates. The nominee, regularly nominated by the delegates present at the nomination meeting pursuant to this section, shall be deemed elected by the House of Delegates at the time of the report of the Secretary-Treasurer. In the event that the delegates from a councilor district fail to submit a nomination, the House of Delegates shall, on its own account, proceed to make nominations from the floor of the House, and in such event a vote shall be taken by the House of Delegates to determine which nominee shall be elected to the vacant councilorship.

* * *

Speaker Roblee stated that this being a constitutional amendment, it would lie over until the 1938 session of the House of Delegates.

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(e) Legislation. Introduced by Dr. Loren R. Chandler of San Francisco. (See p. 423.)

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Speaker Roblee referred the resolution to Reference Committee No. 2.

* * *

(f) Blind Assistance under Social Security. Introduced by Dr. Wilber Swett of San Francisco. (See p. 421.)

* * *

Speaker Roblee referred the resolution to Reference Committee No. 2.

* * *

(g) Individual Responsibility and Paternalistic Aid. Introduced by Dr. L. A. Alesen of Los Angeles. (See p. 422.)

* * *

Speaker Roblee referred the resolution to Reference Committee No. 2.

* * *

(h) Nonprofit Hospital Tax Repeal. Introduced by Dr. Frank A. MacDonald of Sacramento. (See p. 420.)

* * *

Speaker Roblee referred the resolution to Reference Committee No. 2.

18. Approval of Minutes.—Upon motion of Henry Ullmann of Santa Barbara, seconded by Frank A. Makinson of Oakland, the Speaker of the House of Delegates, the Chairman of the Council, and the Secretary of the Association, were authorized to edit the electrically transcribed minutes of the meeting of the House of Delegates.

19. In Memoriam.—In compliance with the action of the House of Delegates, the Speaker now called upon the Secretary of the Association to accord suitable tribute to those of our members who passed out of life during the past year. At the conclusion of the memorial address, the House stood in silence and attention for a brief moment in honor and respect of these deceased members. (Note: See Pre-Convention Bulletin for list of deceased members.)

20. Recess.—At 10:45 p. m. the Speaker declared the House in recess until the second meeting, to be held on Wednesday, May 5, 1937, at 8:15 p. m.

* * *

SECOND MEETING

WEDNESDAY, MAY 5, 1937

21. Call to Order.—The House of Delegates was called to order by Speaker William W. Roblee at 8:15 p. m. on Wednesday, May 5, 1937.

22. Organization and Roll Call.—Stanley S. Mentzer, Chairman of the Credentials Committee, stated that the Committee had seated 111 delegates. The Speaker ruled that, as the Secretary called the roll, the chairman of each

delegation should submit for acceptance and seating as delegates, substitutes for regularly elected delegates not present at this meeting. The Secretary thereupon called the roll by counties, and county delegations filled their lists of delegates. At the conclusion of the roll call the Speaker declared 137 accredited delegates seated and constituting the House of Delegates for this meeting. The names of delegates who registered present follows:

ROLL CALL—SECOND MEETING

OFFICERS

E. M. Pallette
Howard Morrow
W. W. Roblee
J. H. Graves
M. R. Gibbons
J. B. Harris
K. L. Schaupp
C. A. Dukes
G. H. Kress
C. L. Emmons
C. R. Howson
H. J. Ullmann
A. E. Anderson
A. L. Phillips
O. D. Hamlin
C. E. Schoff
H. S. Rogers
H. H. Wilson
C. O. Tanner
W. H. Kiger

Alameda County

O. O. McAllister
H. Snook
J. Dougherty
E. N. Ewer
T. C. Lawson
H. G. Maclean
F. Makinson
Roy Nelson
George G. Reinle
— Smith

Butte County

N. T. Enloe

Fresno County

H. A. Randel
G. W. Walker
E. R. Scarboro

Kern County

C. S. Compton

Los Angeles County

E. Vincent Askey
Harry Wiley
J. V. Barrow
Harry V. Brown
H. L. Charles
F. B. Clarke
Otto H. Barnes
J. W. Crossan
W. H. Daniel
G. De Mott Sedgwick
A. B. Hromadka
Alvin G. Foord
H. V. Soper
Lowell S. Goin
J. Norman O'Neil
J. J. Crane
William H. Leake
Wilbur Bailey
George D. Maner
William R. Molony, Sr.
William E. Beck
Julius Kahn
John W. Nevius
J. P. Nuttall
James F. Percy
Charles E. Phillips
L. A. Alesen
F. M. Pottenger, Sr.
F. M. Pottenger, Jr.
W. W. Hutchinson
Edwin Dewey
E. T. Remmen
Adolph Keutzmann
E. Max Anderson
V. J. Keating
Hyman Miller
H. B. Breilsmann
Dwight Young
V. L. Andrews
Walter F. Wessels
Howard F. West
H. A. Putnam

Marin County

Carl W. Clark

Mendocino-Lake County

Ruggles A. Cushman

Merced County

E. A. Jackson

Monterey County

Mast Wolfsohn
James H. McPharlin

Napa County

George I. Dawson

Orange County

G. Wendell Olson
Dexter Ball

Placer County

Lucas W. Empey

Riverside County

Phillip Corr
Bon O. Adams

Sacramento County

F. A. MacDonald
Paul Guttman
F. N. Scatena

San Bernardino

A. L. Weber
R. Moose
H. G. Gentry

San Diego County

F. E. Toomey
Hall Holder
S. J. McClendon
A. J. Cooper
W. H. Newman

San Francisco County

H. C. Bell
J. W. Cline
E. J. Best
L. H. Garland
E. L. Bruck
L. R. Chandler
G. D. Delprat
Thomas E. Gibson
Philip Gilman
Ernst Gehrels
Irving Ingber
N. J. Howard
Stanley Mentzer
Roland F. Seitz
Robert S. Stone
Wilber Swett
Rodney Yoell
Alson Kilgore

San Luis Obispo County

James M. Marshall

San Mateo County

Hartzell H. Ray
J. Garwood Bridgman

Santa Barbara County

H. E. Henderson
Irving Willis
William H. Eaton

Santa Clara County

C. M. Burchfiel
C. Kelly Canelo
R. Stanley Knechshaw
Russel V. Lee

Santa Cruz County

F. E. Blaisdell, Jr.

Shasta County

C. L. Kay

Solano County

John W. Green

Sonoma County

F. O. Butler
Carol B. Andrews

Stanislaus County

R. Stewart Hiatt

Tulare County

J. C. McClure

Ventura County

A. A. Morrison

Yolo-Colusa-Glenn County

C. S. Roller

23. **Announcement of 1938 Meeting Place.**—The Speaker announced that the Council recommended that the 1938 annual session be held at the Hotel Huntington, Pasadena. On motion of Henry J. Ullmann of Santa Barbara, seconded by Philip Gilman of San Francisco, the recommendation of the Council was approved by the House.

24. **Election of Officers.**—Speaker Roblee relinquished the chair to Vice-Speaker John H. Graves, who declared that nominations were now in order for the office of president-elect.

(a) *President-Elect.*—Bon O. Adams of Riverside nominated William Wallace Roblee of Riverside as president-elect. The nomination was seconded by Charles A. Dukes of Oakland and John P. Nuttall of Los Angeles. On motion of Henry J. Ullmann of Santa Barbara, seconded by A. E. Anderson of Fresno, the Secretary was instructed to cast the ballot of the House for William Wallace Roblee as president-elect. The Secretary did so cast, and the Vice-Speaker ruled that William Wallace Roblee was duly elected to the office of president-elect.

Doctor Roblee in a very gracious and suitable manner expressed his appreciation for the honor that had been accorded him.

Speaker Roblee then resumed the Chair.

(b) *Speaker.*—The Speaker recognized Carl R. Howson of Los Angeles, who placed in nomination for the office of Speaker, Lowell S. Goin of Los Angeles. The nomination was supported by Loren R. Chandler of San Francisco. On motion of Charles A. Dukes of Oakland, seconded by Howard Morrow of San Francisco, the Secretary was instructed to cast the ballot of the House for Lowell S. Goin. The secretary did so cast, and the Speaker announced the election of Lowell S. Goin as Speaker of the House for the ensuing year.

Doctor Goin responded in a very happy vein, thanking the delegates for the honor accorded him and pledging the discharge of the duties of office in an impartial and efficient manner.

(c) *Vice-Speaker.*—The Speaker recognized Ruggles A. Cushman of Talmage, who exercised his prerogative established by precedent in naming the vice-speaker of the House, and placed in nomination the name of John H. Graves of San Francisco. This nomination was seconded by Irving Ingber of San Francisco. On motion of William H. Kiger of Los Angeles, seconded by N. T. Enloe of Chico, the Secretary was instructed to cast the ballot of the House for John H. Graves. The Secretary did so cast, and the Speaker declared John H. Graves elected Vice-Speaker for the ensuing year.

25. Election of Councilors:

(a) *Third District.*—The delegates of the Third Councilor District, representing the counties of Santa Barbara, San Luis Obispo, and Ventura, submitted in writing the nomination of Henry J. Ullmann of Santa Barbara as councilor of the Third District, to succeed himself.

C. S. Compton of Bakersfield placed in nomination the name of Louis Packard of Bakersfield as councilor of the Third District. The Speaker directed that ballots be spread and appointed five tellers. Upon completion of the count the Secretary announced that 128 out of a possible 137 votes had been cast, Louis A. Packard receiving 83 and Henry J. Ullmann receiving 45.

The Speaker, therefore, declared Doctor Packard elected councilor of the Third District for the ensuing three years.

(b) *Sixth District.*—Delegates for the Sixth District placed in nomination the name of Karl L. Schaupp of San Francisco to succeed himself. The nomination was seconded by Loren Chandler of San Francisco. On motion of Loren R. Chandler, seconded by Howard Morrow of San Francisco, the Secretary was instructed to cast the ballot. The Secretary did so cast the ballot, and the Speaker declared Karl L. Schaupp elected councilor of the Sixth District for the ensuing three years.

(c) *Ninth District.*—The delegates from the Ninth District placed in nomination the name of Henry S. Rogers to succeed himself as councilor of the Ninth District. Karl L. Schaupp of San Francisco moved that the Secretary cast the ballot; seconded by A. E. Anderson of Fresno. The Secretary did so cast, and the Speaker declared Henry S. Rogers elected as councilor for the Ninth District for the ensuing three years.

(d) *Councilor-at-Large.*—John P. Nuttall of Los Angeles, placed in nomination the name of William H. Kiger of Los Angeles to succeed himself as councilor-at-large. The nomination was supported by George G. Reinle of Oakland. Upon motion of Harry H. Wilson, seconded by C. A. Dukes, the Secretary was instructed to cast the ballot for Doctor Kiger. The Secretary did so cast, and the Speaker declared William H. Kiger of Los Angeles elected councilor-at-large to succeed himself for the ensuing three years.

(e) *Councilor-at-Large.*—Karl L. Schaupp of San Francisco placed in nomination the name of Junius B. Harris of Sacramento to succeed himself as councilor-at-large. The nomination was seconded by a rising demonstration of the House. On motion of E. Vincent Askey of Los Angeles, seconded by N. T. Enloe of Chico, the Secretary was instructed to cast the ballot of the House. The Secretary did so cast, and the Speaker announced the election of Junius B. Harris of Sacramento to succeed himself as councilor-at-large for a period of three years.

26. Delegates to the House of Delegates of the American Medical Association:

(a) William H. Kiger of Los Angeles nominated Elbridge J. Best of San Francisco to succeed himself as delegate to the American Medical Association. This nomination was seconded by Morton R. Gibbons of San Francisco. On motion of George G. Reinle of Oakland, seconded by Loren R. Chandler of San Francisco, the Secretary was instructed to cast the ballot. The Secretary did so cast, and the Speaker announced the election of Elbridge J. Best of San Francisco as delegate to the American Medical Association for the sessions of 1938 and 1939.

(b) F. E. Toomey of San Diego nominated Lyell C. Kinney of San Diego to succeed himself as delegate to the American Medical Association. The nomination was seconded by H. Wiley of Los Angeles. On motion of Karl L. Schaupp of San Francisco, seconded by Philip Gilman of San Francisco, the Secretary was instructed to cast the ballot of the House. The Secretary did so cast, and the Speaker announced the election of Lyell C. Kinney of San Diego as delegate to the American Medical Association for the sessions of 1938 and 1939.

(c) Fred B. Clarke of Los Angeles nominated John P. Nuttall of Los Angeles to succeed Doctor Clarke as delegate to the American Medical Association. The nomination was seconded by William H. Kiger. On motion of William H. Kiger of Los Angeles, seconded by Stanley H. Mentzer of San Francisco, the Secretary was instructed to cast the ballot. The Secretary did so cast, and the Speaker declared John P. Nuttall elected delegate to the American Medical Association for the sessions of 1938 and 1939.

27. Alternates to the House of Delegates of the American Medical Association:

(a) Irving S. Ingber of San Francisco placed in nomination the name of Robert S. Stone of San Francisco as alternate to Elbridge Best to the American Medical Association. There being no further nominations, the Speaker declared the nominations closed. On motion of Howard Morrow of San Francisco, seconded by George G. Reinle of Oakland, the Secretary was instructed to cast the ballot. The Secretary did so cast, and the Speaker declared Robert S. Stone elected alternate to Elbridge Best to the American Medical Association sessions of 1938 and 1939.

(b) Harry H. Wilson of Los Angeles placed in nomination the name of Bon O. Adams of Riverside as alternate to Lyell C. Kinney to the American Medical Association. There being no further nominations, the Speaker declared the nominations closed. On motion of George G. Reinle of Oakland, seconded by William H. Kiger of Los Angeles, the Secretary was instructed to cast the ballot. The Secretary did so cast, and the Speaker declared Bon O. Adams of Riverside elected alternate to Lyell C. Kinney to the American Medical Association sessions of 1938 and 1939.

(c) William R. Molony, Sr., of Los Angeles placed in nomination the name of F. M. Pottenger, Sr., of Monrovia as alternate to John P. Nuttall to the American Medical Association. There being no further nominations the Speaker declared the nominations closed. On motion duly made and seconded, the Secretary was instructed to cast

the ballot. The Secretary did so cast, and the Speaker declared F. M. Pottenger, Sr., elected alternate to John P. Nuttall to the American Medical Association sessions of 1938 and 1939.

28. Constitutional Amendments:

The following constitutional amendments having been proposed at the Coronado session, and having been published in the official JOURNAL of the Association, were now presented to the House for action:

(a) *Amendment Placing the Past President of Each Year on the Council for one year.*

Resolved, That Section 1 of Article VII of the Constitution of this Association be and is hereby amended by inserting in the first paragraph thereof after the words "the president," the following: "the past president"; and be it further

Resolved, That Section 8 of Article VII of the Constitution of this Association be and is hereby amended by inserting in the first paragraph thereof after the words "the president," the following: "the past president"; and be it further

Resolved, That Section 1 of Article X of the Constitution of this Association be and is hereby amended by inserting after the words "a president," the following: "a past president"; and be it further

Resolved, That Section 2 of said Article X of the Constitution of this Association and the title thereto be amended to read as follows:

"Section 2. President-Elect, when and how elected; term of office. Past president.

"The House of Delegates at the regular annual session thereof shall elect the president-elect to serve until the adjournment of the final meeting of the House of Delegates at its next regular annual session. At the conclusion of the final meeting of the House of Delegates at its next regular annual session, such president-elect shall assume the office of president, and serve as such for the term of one year thereafter, or until his successor assumes office.

"At the expiration of his term of office the president shall become the past president and serve as such for a term of one year thereafter, or until his successor assumes office; and be it further

Resolved, That Section 4 of Article X of the Constitution of this Association be and is hereby amended by inserting in the first paragraph thereof after the word "president," the following: "past president."

* * *

William R. Molony, Sr., of Los Angeles, seconded by Clifford Mack of Livermore, moved the adoption of the amendment. Discussion was engaged in by Doctors Robert A. Peers of Colfax, Loren R. Chandler of San Francisco, and George G. Reinle of Oakland.

On a rising vote, the Speaker declared the amendment adopted with 103 affirmative votes.

* * *

(b) *Amendment Outlining Conditions Applying to House of Delegates' Appropriations in Excess of \$1,000.*

Resolved, That Section 1 of Article XI of the Constitution of this Association be and is hereby amended as follows:

By striking out all of the fourth paragraph of said Section 1 of Article XI, reading as follows:

"All resolutions providing for appropriations shall be referred to the Council, and all appropriations approved by the Council shall be included in the annual budget."

And by inserting in lieu thereof the following:

"Any resolution passed and adopted by the House of Delegates at any regular or special session thereof, which provides for or contemplates the appropriation or expenditure of more than the sum of \$1,000 shall not be effective for any purpose unless and until approved by the Council. All appropriations, regardless of amount, approved and made by the Council shall, if expended, be reported to the House of Delegates at its next annual session, and any unexpended portion of any thereof shall be included in the annual budget."

William R. Molony, Sr., of Los Angeles, seconded by F. M. Pottenger, Sr., of Monrovia, moved the adoption of the amendment. On a rising vote, the Speaker declared the amendment adopted.

29. **Nominations for Standing Committees.**—Under instruction of the Council, the Secretary presented the following nominations for standing committees for approval

by the House of Delegates, and on motion of Irving Ingber of San Francisco, seconded by Fred B. Clarke of Long Beach, the membership of standing committees was approved by the House:

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

John V. Barrow (Chairman), Los Angeles.....	1940
Edwin L. Bruck, San Francisco.....	1938
William H. Geistweit, San Diego.....	1939

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

B. W. Black, Oakland.....	1940
Fred B. Clarke (Chairman), Long Beach.....	1938
W. R. P. Clark, San Francisco.....	1939

COMMITTEE ON HISTORY AND OBITUARIES

A. E. Belt, Los Angeles.....	1940
F. R. Makinson (Chairman), Oakland.....	1938
J. Marion Read, San Francisco.....	1939
The Secretary ex officio	
The Editor ex officio	

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Karl L. Schaupp, San Francisco.....	1940
George Dawson, Napa.....	1938
Daniel Crosby (Chairman), Oakland.....	1939

COMMITTEE ON INDUSTRIAL PRACTICE

Harry E. Zaiser, Orange.....	1940
Morton R. Gibbons, Sr. (Chairman), San Francisco.....	1938
Philip Stephens, Los Angeles.....	1939

COMMITTEE ON MEDICAL DEFENSE

John P. Nuttall, Santa Monica.....	1940
George G. Reinle (Chairman), Oakland.....	1938
Fred R. DeLappe, Modesto.....	1939

COMMITTEE ON MEDICAL ECONOMICS

Percy Magan, Los Angeles.....	1940
John H. Graves (Chairman), San Francisco.....	1938
William R. Molony, Sr., Los Angeles.....	1939

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

John B. Doyle, Los Angeles.....	1940
B. O. Raulston, Los Angeles.....	1938
Loren R. Chandler (Chairman), San Francisco.....	1939

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

G. Dan Delprat, San Francisco.....	1940
E. Vincent Askey (Chairman), Los Angeles.....	1938
Dewey R. Powell, Stockton.....	1939

COMMITTEE ON POSTGRADUATE ACTIVITIES

John C. Ruddock (Chairman), Los Angeles.....	1940
F. E. Clough, San Bernardino.....	1938
F. F. Gundrum, Sacramento.....	1939
The Secretary ex officio	

COMMITTEE ON PUBLICATIONS

Ralph Eusden (Chairman), Long Beach.....	1940
Ruggles A. Cushman, Talmage.....	1938
Oscar Reiss, Los Angeles.....	1939
The Secretary ex officio	
The Editor ex officio	

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

E. T. Remmen, Glendale.....	1940
J. B. Harris (Chairman), Sacramento.....	1938
T. Henshaw Kelly, San Francisco.....	1939
President ex officio	
President-elect ex officio	

30. **Report of the Reference Committee on Reports of Officers and of Standing and Special Committees.**—Dr. Frederick N. Scatena, Chairman of the Reference Committee on Reports of Officers and of Standing and Special Committees, submitted the following comments on the reports of officers, councilors, and standing and special committees.

REPORT OF THE COMMITTEE

Report of the President.—President Pallatte is to be commended for the excellent manner in which he has administered the affairs of the California Medical Association. He has visited many local societies, has been instrumental in increasing the membership of the California Medical Association to 85 per cent of the eligible practicing physicians in the State. His request that special effort be made to enroll as large a number as is possible of the 1,200 non-

members who are eligible and residing in the Los Angeles and San Francisco areas is to be commended.

Your Committee especially commends Doctor Pallette for the fine coöperation he has obtained from his standing committees and for his efforts in behalf of public education in scientific medicine achieved through the excellent exhibits maintained by the California Medical Association.

The Committee recommends adoption. *Carried.*

* * *

Report of the President-Elect.—The California Medical Association has in the past demonstrated excellent judgment in the selection of its presidents. In Dr. Howard Morrow, your Committee feels we have a man who, because of his long experience in executive and administrative offices, is particularly well qualified to carry on the traditions of the California Medical Association in a manner that will reflect advancement and prosperity to the California Medical Association.

The Committee recommends adoption. *Carried.*

* * *

Report of the Speaker of the House of Delegates.—Speaker Roblee is to be commended for the excellent manner in which he has conducted the meetings of the House of Delegates. His knowledge of parliamentary law and his interest in the faithful execution of the duties of this office have helped in no small measure to make this year the successful one that it is.

The Committee recommends adoption. *Carried.*

* * *

Report of the Council.—The report of the Council points out that the members thereof have given of their time and effort in the performance of Association duties, and all of the members of the Secretary-Treasurer's staff have worked in conjunction with the Council, as have the Editor of the JOURNAL and the General Counsel.

* * *

The recommendation to the House of Delegates that the annual Association dues be \$10 for the year 1938 is especially commended. *Carried.*

* * *

The Committee notes with gratification the large increase in membership and recommends that special effort be made by the county societies to enroll all the eligible men in their immediate districts, and that the large metropolitan areas of Los Angeles and San Francisco be especially requested to exert every effort to enroll the large numbers in their areas who are at present not members. *Carried.*

* * *

Your Committee recommends that, in the proposed plan or organization of the consolidated sections, a committee be formed consisting of the chairman of each section and the Secretary of the California Medical Association, and that each section receive recognition especially in the matter of selection of officers, selection of papers, allocation of papers and time, and that each section be given a voice in the selection of guest speakers.

After a discussion as to whom the power is vested in to select guest speakers for annual meetings, the Association Secretary, Doctor Warnshuis, pointed out that the Scientific Committee makes recommendations to the Council, which body selects guest speakers. Dr. Charles E. Schoff of Sacramento stated that no plan for the consolidation of sections had been adopted, therefore there was no need for this portion of the report. The portion of the report dealing with consolidation of sections—*Not carried.*

* * *

Your Committee feels that the Committee on Legislation and Public Policy is thoroughly capable of handling all problems which confront it. The excellent work of these men under the able leadership of Dr. Junius B. Harris is such that we find it impossible to express in words the appreciation which we know the members of the California Medical Association feel toward them.

The Committee recommends adoption. *Carried.*

* * *

Your Committee endorses the desirability of the San Francisco County Medical Society entertaining the American Medical Association in San Francisco in the year 1938. The Committee recommends that the California Medical

Association delegates to the American Medical Association be instructed to make a special effort to obtain the convention. *Carried.*

* * *

Your Committee has observed from the annual report of several standing committees, such as the Committee on Hospitals, Dispensaries and Clinics, the Committee on Industrial Practice, the Committee on Medical Economics, and the Committee on Medical Education and Medical Institutions, that no meetings have been held during the past year and that any matters pertinent to the said committees which have arisen have been referred to other committees. Your Committee feels that a study of the needs for consolidation of standing committees should be made and that all committees considered unnecessary be deleted and others deemed necessary, because of new standards and conditions, be added.

* * *

(b) Resolution Regarding Annual Conference of Standing Committees

WHEREAS, The By-Laws of the California Medical Association provide for the appointment of certain standing committees, each group having distinct responsibilities concerning activities of the California Medical Association; and

WHEREAS, In order to have the profession of the various parts of the State properly represented, each committee consists of members who live in different sections of California; and

WHEREAS, Because of the size of the State, the expense of travel is considerable, so that these important standing committees up to the present time have not had opportunity to function either at or between annual sessions; and

WHEREAS, It would be of real benefit to the interest of organized and scientific medicine and of the California Medical Association and its component county societies if these California Medical Association standing committees would be given opportunity to function to better advantage; now, therefore, be it

Resolved, By the House of Delegates of the California Medical Association that it recommend that the Council take steps to provide that all standing committees shall be called together for joint and individual meetings at the same time and place, not only at the annual session, but at least once in the mid-year between annual sessions, at such place and time as the Council may decide, the railroad expense of the members of the standing committees for the mid-year meeting to be paid by the Association.

In the Secretary-Treasurer's annual report, there are suggestions incorporating the subject matter of the Barrow resolution, and we endorse the resolution as modified by the suggestions made in the report of the Secretary-Treasurer, Doctor Warnshuis. The suggestions are as follows:

1. The re-creation of certain standing committees and the abolishment of others.
2. The holding in October of each year of a two-day session for an annual conference of county secretaries and the members of the standing committees.

The Committee recommends adoption of this section of the report. *Carried.*

* * *

Report of District Councilors.—Your Committee notes from the reports of the District Councilors that they have fulfilled the duties of their respective districts. Special commendation should be given to these councilors, and particularly to Doctors Rogers and Schoff, who, because of the vastness of their respective districts, have had to travel great distances to reach the component societies.

The Committee recommends adoption. *Carried.*

* * *

Report of the Secretary-Treasurer.—The Secretary-Treasurer, in conjunction with the President, has visited many of the local societies and, in addition, has met with many public clubs and made contacts with other associations for the purpose of spreading knowledge of the work done by organized medicine. Your Committee has noted the suggestions made at the end of the Secretary's report and submits the following comments and suggestions concerning adoption thereof:

1. The re-creation of certain standing committees and the abolishment of others.

2. The holding in October of each year of a two-day session for an annual conference of county secretaries and members of standing committees.

The above suggestions have been adopted by a previous vote here, and we believe they are steps forward which will make for better and more intelligent management of the affairs of the various committees. As for the remainder of the suggestions:

1. The establishment of permanent headquarters.
2. The establishment of a packet library reference service.
3. The solicitation of funds for the establishment of a permanent endowment fund.

Your Committee feels that, with the insufficient information at hand, the above questions should be presented at a later meeting.

4. The sponsoring of an annual conference of representatives of the three Pacific Coast state organizations.

Your Committee feels that the establishment of such a relation between the Pacific Coast states may be of advantage. However, it feels that the Council should, after adequate study of the proposed plan, decide as to its establishment.

The Committee recommends adoption of this modified report. *Carried.*

* * *

Report of the Editor.—Your Committee recommends that the first page of CALIFORNIA AND WESTERN MEDICINE be kept free of advertising. It also recommends continuation of permanent locations in CALIFORNIA AND WESTERN MEDICINE for departmental matters. We feel that the Journal has achieved a place of importance, and we recommend that its high standard be continued in the future.

The Committee recommends adoption.

The report was changed to read, "the front cover of CALIFORNIA AND WESTERN MEDICINE" in place of "first page." The report as changed was *carried*.

* * *

Report of the Legal Department.—The report of the Legal Department shows increased activity, special attention having been given to such matters as the disciplinary appeal of members to the Judicial Council of the American Medical Association, the matter relative to the status of expert witnesses and also to the matter of modification of the Business and Professional Code of California.

Your Committee especially commends the idea of issuing a physician's handbook as proposed by the Counsel. Valuable work was done in clarifying the relationship between hospital insurance service and the policies of the California Medical Association. We hope this type of service will continue in the future.

The Committee recommends adoption. *Carried.*

* * *

Report of the Committee on Associated Societies and Technical Groups.—The report as submitted by Dr. W. J. Kerr shows the increasing importance of the Woman's Auxiliary to the California Medical Association and everything possible should be done to guide and encourage these activities along proper lines. We feel that the local component medical societies should work in close relationship with their respective auxiliaries in any proposed activity in which the help of the Auxiliary is requested.

The Committee recommends adoption. *Carried.*

* * *

Report of the Committee on History and Obituaries.—Your Committee recommends that the question of gathering historical data be left to the component county societies and that when these compilations are completed, a copy thereof be sent to the California Medical Association so the collection in its entirety would give the historical background of the entire State of California. Your Committee also recommends that this matter be brought to the attention of the secretaries at the annual conference of secretaries.

We view with a great deal of regret the large number of our brothers who have passed to the "great beyond." We

know that in their respective communities and in the State in general, the memory of their work will linger.

The Committee recommends adoption. *Carried.*

* * *

Report of the Committee on Medical Education and Medical Institutions.—Your Committee feels that membership activities should be relegated to the component county units. However, we appreciate the work this committee has done thus far, and we feel it should be commended for the coöperation secured between the county societies and the State Association.

The Committee recommends adoption. *Carried.*

* * *

Report of the Committee on Postgraduate Activities.—Your Committee urges the adoption, as far as possible, of the recommendations set forth in the annual report of the Committee on Postgraduate Activities. To facilitate the work of this committee, we recommend that the membership be increased from three to five members.

The Committee recommends adoption. *Carried.*

* * *

Report of the Committee on Publications.—The recommendations set forth in this report are incorporated in the Editor's report, and have received the approval of this committee.

The Committee recommends adoption. *Carried.*

* * *

Report of the Committee on Scientific Work.—Your Committee commends the Committee on Scientific Work for their efforts in the development of a department of scientific exhibits.

The following resolution is set forth in this report:

Resolved, That the second general session of each annual meeting shall be devoted to a Clinico-Pathological Conference conducted under the auspices of the Scientific Committee.

Your Committee recommends that the House of Delegates go on record as requesting the Scientific Committee to include a Clinico-Pathological Conference whenever an especially interesting program can be arranged at the second general session.

The Committee recommends adoption. *Carried.*

* * *

Report of the Committee on Public Relations.—With regard to the recommendations set forth in this report, your Committee recommends that Health Institutes be discontinued and educational films be instituted therefor. Because of the wide scope of the clinical problems and the many issues involved in the establishment of a Public Health Hour in physicians' offices, your Committee recommends that this suggestion be not acted upon at the present time.

Your Committee feels that the expenditure involved in acquiring a library of educational films for public meetings is too great to be handled by the State Association and should be a function of the American Medical Association.

* * *

Referring to the Supplementary Report on Medical Exhibits at the 1936 California-Pacific International Exposition at San Diego, your Committee feels duty-bound to express to these gentlemen the highest regard and appreciation for the time and money expended in the maintenance, continuation, and expansion of the exhibits at the San Diego Fair. Your attention is expressly called to Doctor Geistweit's report, wherein he commends both Dr. M. C. Harding and Dr. L. C. Kinney for the fine work these gentlemen accomplished and for which they have so modestly refused recognition.

The Committee recommends adoption. *Carried.*

* * *

Report of the Auditing Committee.—This report in brief was published in the Pre-Convention Bulletin. The Committee makes no comment upon it and moves its adoption. *Carried.*

The California Medical Association's proposed budget for the year 1938-1939 was presented by Dr. Karl Schaupp at the first meeting of the House of Delegates. (See Item 11, page 412.)

Examination of the proposed budget for 1938-1939 suggests the following recommendations by Reference Committee No. 1:

1. We feel that the Association expenses have reached a maximum peak and should not increase over the present amount unless some great emergency should require greater expenditures.

2. Your Committee suggests that the group costs, such as salaries, retainers' fees and other expenses, be broken down to show exactly where the various amounts are used.

3. We recommend a uniform breakdown plan to be followed yearly in future reports.

4. We recommend that the budget be made for the fiscal year beginning January 1 and ending December 31 each year, and be based on anticipated income received during this period.

5. We heartily approve the new audit plan which was placed in use this year.

The Committee recommends adoption. *Carried.*

* * *

Report of the Cancer Commission.—The Cancer Commission has done good work, and your Committee urges the continuation of this important field of research.

The Committee recommends adoption. *Carried.*

* * *

Report of the Special Committee on Qualifying Certificate Law.—Although your Committee is in favor of the passage of the qualifying certificate law, it does not feel that the expenditure of the moneys necessary therefor is feasible at this time, and recommends that this matter be held over for another year.

The Committee recommends adoption.

* * *

After an explanation of the necessity of a qualifying certificate law in this State by Dr. George H. Kress of Los Angeles and Dr. Lowell S. Goin of Los Angeles, a vote was taken and the motion did *not* carry.

* * *

Report of the Committee of Five.—Your Committee recommends that steps be taken to expedite the settlement of this question and to clean the slate as rapidly as possible.

Your Committee recommends adoption.

* * *

On the grounds that the recommendations of the Committee were not clearly stated or defined, a vote was taken and the motion did *not* carry.

* * *

Report of the Special Committee of the California Medical Association Dealing with Hospital Radiology and Pathology.—The report of the Special Committee of the California Medical Association Dealing with Hospital Radiology and Pathology, as presented by Dr. Charles A. Dukes at the first meeting of the House of Delegates, was read by Doctor Scatena.

Text of the Report

This is the final report of the Special Committee of the California Medical Association dealing with hospital radiology and pathology. The Committee has held several meetings during the last few years to consider the solutions of the problems concerned. On March 8, 1935, a joint meeting was held between the Committee and a Special Committee of the Western Hospital Association. At that meeting Dr. Benjamin Black, representing the hospitals, and Dr. Lowell Goin representing the physicians, were appointed a committee of two to formulate the principles governing the practice of radiology and clinical pathology

within the hospitals, and the following points were arrived at:

1. It is the judgment of this joint Committee that the practice of radiology and the practice of clinical pathology are, in every particular, integral parts of the practice of medicine, that it is necessary that a hospital operating a department of radiology and clinical pathology is justly entitled to: (a) a sum which is adequate rental for the space occupied; (b) reasonable amounts for depreciation and obsolescence; (c) all necessary costs accrued in the operation of such departments; (d) a reasonable return on its invested capital; (e) a reasonable amount over and above these charges to create a sinking fund against contingency.

The compensation of the roentgenologists and the pathologists shall be all the moneys received by the respective departments over and above the admitted fixed charges enumerated above, collection and distribution of the fees to be by method agreed upon between the executives of the hospital and the roentgenologist and/or the pathologist.

That employees serving the similar departments of roentgenology and pathology will be considered as part of the staff of the hospital, subject to similar executive control as may be applied to other employees but professionally responsible to the roentgenologist or pathologist serving in charge of the respective departments, employees in the departments to be removed for cause upon recommendation of the head of the department.

In furtherance of the above, and in view of the developments and conclusions reached in the past twelve months, your Committee wishes to recommend that the following specific proposals be promulgated by the Council of the California Medical Association for the guidance of physicians in relation to hospitals and the guidance of hospitals in relation to physicians, especially in connection with physicians practicing radiology and pathology:

1. Private hospitals: A lease type of arrangement. The physician should rent space and equipment or space alone from the hospital, paying the latter a monthly or annual sum therefor, this sum being adequate to assure an equitable return to the hospital. It is essential that the hospital receive reasonable remuneration for space occupied and equipment used.

Bills should be sent directly to the patient by the radiologist or the pathologist on his own billhead, as is customary for other physicians. The hospital office need not be asked to handle the collection for him. The radiologist or pathologist should be selected by the executive medical staff of the hospital on the basis of professional ability, standing, and qualifications.

2. University hospitals: As far as patients are concerned, the same arrangements outlined under (1) should apply. However, if all of the other members of the medical staff are on a salary basis or secure their compensation in some similar manner, then it is not inequitable for the staff radiologist or pathologist to be treated in the same manner as are their medical confrères.

3. Municipal, state, and federal hospitals: Since no fees are collected from patients in these hospitals for medical services, the problem of hospital-physician relationship in regard to the private practice of medicine does not arise.

In summary, therefore, we urge the members of the California Medical Association, particularly those who are on the executive boards of hospitals, to present these carefully formulated recommendations to their respective hospitals, to the end that all physicians practicing radiology and pathology in their institutions shall do so on a legal and ethical basis. The welfare of the patients and the welfare of the hospital will then be assured. The status of these physicians with respect to private practice should be essentially the same as that of the surgeon, internist, and other clinical specialists.

* * *

Your Committee recommends the adoption of the report of the Special Committee of the California Medical Association on Hospital Radiology and Pathology with the following corrections:

In paragraph 1, page 2 of the report, on private hospitals, after the words "lease type" add "rental or similar type of arrangement"; and delete the following: "Bills should be sent directly to the patient by the radiologist or the pathologist on his own billhead, as is customary for other physicians. The hospital office need not be asked to handle the collections for him." We delete this section because we feel it is in conflict with the statement made on page 1, which states: "The compensation of the roentgenologists and pathologists shall be all the moneys received by the respective departments over and above the admitted fixed charges enumerated above, collection and distribution of the fees to be by method agreed upon between the ex-

ecutive of the hospital and the roentgenologist or the pathologist."

Your Committee recommends adoption as amended. *Carried.*

* * *

Report of The Trustees Of The California Medical Association.—Your Committee has examined this report and moves its adoption (Supplement, April, 1937. CALIFORNIA AND WESTERN MEDICINE, page 39). *Carried.*

* * *

Report of the Local Committee on Arrangements.—We are now terminating the sixty-sixth annual session of the California Medical Association, and many pleasant memories will remain of the hospitality of the Monterey County Medical Society and the splendid accommodations and service rendered by the hotel management of the Hotel Del Monte. Your Committee thanks the local Committee on Arrangements and the Monterey Society for their hospitality and thoughtfulness.

The Committee recommends adoption. *Carried.*

✓ ✓ ✓

The above report is signed:

COMMITTEE ON REPORTS OF OFFICERS AND STANDING
AND SPECIAL COMMITTEES.

By Frederick N. Scatena, *Chairman.*

Louis A. Packard

John P. Nuttall

✓ ✓ ✓

On motion duly made and seconded, the report of the Reference Committee on Reports of Officers and of Standing and Special Committees was adopted as amended.

31. Report of Committee on Public Policy and Legislation.*—The Speaker called attention to the report of the Committee on Public Policy and Legislation as submitted at the third general session. Dr. Junius B. Harris then made several explanatory remarks, and also reported that at a conference an agreement had been reached between the State Department of Health and those who were sponsoring another venereal disease control bill in the present session of the legislature. This was discussed by Dr. Russell Lee of Palo Alto and Dr. Howard Morrow of San Francisco.

Dr. Howard Morrow moved that the report of the Committee on Public Policy and Legislation be adopted. This motion was seconded by Dr. C. A. Dukes, and carried.

32. Venereal Disease Control.—Howard Morrow of San Francisco, Chairman of the Association's Committee on Venereal Disease Control, submitted the following report:

At a meeting of the Committee of the California Medical Association on the Control of Venereal Diseases, held May 4, 1937, the following recommendations were drawn up:

1. We urge the use of modern methods in the diagnosis and treatment of syphilis.
2. We urge diagnosis at the earliest possible moment.
3. We urge the tracing of sources of infection, investigation of contacts and the following up of delinquent venereal disease patients.
4. We urge the reporting of all cases as prescribed by the California State Board of Health.
5. We urge the full cooperation of the private physician with public health agencies. This cooperation is most important.
6. We urge the taking of a blood Wassermann on every pregnant woman. Any woman who has had syphilis should be treated during each pregnancy regardless of the blood Wassermann reaction.
7. We urge the continuation of professional secrecy between physician and patient in so far as is possible in compliance with the rules of the State Board of Health.

* See also in this issue of CALIFORNIA AND WESTERN MEDICINE, item 13 of House of Delegates minutes (page 412) and editorial comments presenting a digest of the report (page 364).

8. We recommend that the California Medical Association take the initiative in the development of a venereal disease educational program for the physicians of the state.

(Signed): WILLIAM H. GOECKERMAN,
Los Angeles.

CHARLES W. BARNETT,
San Francisco.

HOWARD MORROW, *Chairman.*
San Francisco.

✓ ✓ ✓

On motion of Russell V. Lee, seconded by A. E. Anderson, the report of the Committee was adopted.

42. Report of Reference Committee No. 2 on Resolutions and New and Miscellaneous Business.—Lowell S. Goin of Los Angeles, Chairman of Reference Committee No. 2, stated that his report covered ten resolutions. With the unanimous consent of the House, Doctor Goin dispensed with the re-reading of the resolutions as introduced in the first meeting.*

✓ ✓ ✓

*(h) Resolution Regarding Nonprofit Hospital
Tax Repeal*

WHEREAS, Hospitalization insurance as provided by nonprofit hospitalization associations has proved of great benefit to the medical profession and to the general public; and

WHEREAS, The type of hospitalization insurance provided by nonprofit associations conforms to the ideals and ethics of the medical profession; and

WHEREAS, Nonprofit hospitalization insurance associations must be relieved of all unnecessary expense in order to continue providing this type of hospitalization insurance at minimum cost to the public; therefore be it

Resolved, That the California Medical Association exert its influence with the State Administration to repeal state taxation of nonprofit hospitalization insurance associations.

✓ ✓ ✓

On the resolution introduced by Frank A. MacDonald of Sacramento, on advice of legal counsel and the consent of Doctor MacDonald, the Committee offers the following substitute resolution:

WHEREAS, The Constitution of the State of California provides for the imposition of a tax of 2.6 per cent on the gross premiums incurred by all insurers; and

WHEREAS, This tax constitutes a serious burden by increasing the cost of hospital insurance to not-for-profit associations formed for the purpose of providing hospital insurance; and

WHEREAS, These plans are a benefit to the public at large, as well as the medical profession; and

WHEREAS, There is now pending in the Legislature of the State of California an assembly constitutional amendment proposing to add a section to Article XIII of the Constitution exempting corporations, associations or insurers organized without capital stock and carried on solely for the mutual benefit of its members and not for profit, from all state, county and municipal taxes; therefore be it

Resolved, That the Legislative Committee of this Association is informed that the House of Delegates of the California Medical Association urges passage of the constitutional amendment.

✓ ✓ ✓

The Committee moves the adoption of the substitute resolution. Seconded by F. N. Scatena of Sacramento, and unanimously *carried*.

* * *

*(a) Resolution Regarding Public Health Education
and Educational Films*

WHEREAS, The public today is seeking and demanding dependable health information and knowledge; and

WHEREAS, This demand is being partly met by self-seeking, non-authentic and non-scientific sources, namely, the advertisers and vendors of remedies, and self-constituted, inadequately educated cults and charlatans; and

WHEREAS, Misleading and false information is being transmitted to the public through the various avenues of publicity which constitute a very definite menace to the

* Editor's Note.—For convenience of readers, the resolutions as presented at the first meeting of the House of Delegates will be printed in place with the recommendations of the committee.

health welfare of the public of this nation and, therefore, demands the concerted action of organized medicine to aid and support the physician in fulfilling his duty to the public as expressed in Sections 1 and 3, Chapter IV of the Principles of Medical Ethics of the American Medical Association; and

WHEREAS, Methods and channels through which educational information is being imparted have materially changed in the past twenty-five years from the written page to the radio, and now to the moving picture with sound-effect; and

WHEREAS, Motion pictures bringing the story of medicine to the public have been used in a very limited way by the profession and by organized medicine; and

WHEREAS, The visual story of medicine in film lends itself to dramatization of great general interest and offers effective means for desirable educational work in the public's behalf, and will create an appreciation of the science of medicine and of those who represent it; and

WHEREAS, Motion-picture films must be of understandable pictorial and dramatic quality that calls for the expenditure of money for scenarial writing of scripts and dialogue; and

WHEREAS, Such moneys cannot be expended by individual physicians or by component county medical units; and

WHEREAS, Motion-picture films of a character contemplated in this resolution should be used nationally to the benefit of the public; therefore be it

Resolved, That the House of Delegates of the California Medical Association at Del Monte, California, in May, 1937, instruct its delegates to the House of Delegates of the American Medical Association meeting at Atlantic City, June 6 to 11, 1937, to introduce and to support a resolution calling upon the Board of Trustees of the American Medical Association to give immediate consideration to the production of educational films, with and without sound-track, and that such films be made available for the various component state and county medical societies throughout the country for these educational purposes.

The Committee feels that this resolution embodies possibilities of incalculable value, and if it were adopted in this House and in the House of Delegates of the American Medical Association and its intentions were carried out properly, the resultant benefit to the medical profession would be enormous.

The Committee moves the adoption of the resolution. Seconded by F. M. Pottenger, Sr., and unanimously *carried*.

(f) *Resolution Regarding Aid to the Blind Under the Social Security Act*

WHEREAS, The Federal Social Security Act in Title Ten having placed on the Social Security Board the responsibility of entering into cooperative arrangements with the various states for the purpose of aiding states in granting financial assistance to needy blind individuals, and the Social Security Board having ruled that individuals in the various states applying for blind assistance must be examined by an ophthalmologist or a physician skilled in diseases of the eye; and

WHEREAS, The Social Security Board has advised the official state agencies having the responsibility of administering this aid in the various states to employ a supervising ophthalmologist, part or full time, who will have general supervision of the medical determination of blindness within the state; therefore be it

Resolved, That the California Medical Association commends the action of the Social Security Board on requiring that applicants for blind assistance within the various states be examined by ophthalmologists or physicians skilled in diseases of the eye, as such a procedure will serve to secure fuller knowledge as to the causes of blindness within the state; be it further

Resolved, That the California Medical Association goes on record as approving the suggestion of the Social Security Board that the official agency in this state, charged with the responsibility of administering blind assistance, employ a supervising ophthalmologist whose duty will be the general supervision of the medical determination of blindness of those needy individuals applying for blind assistance; be it further

Resolved, That since the Social Security Board has ruled that applicants for blind assistance within the various states must be examined by ophthalmologists or physicians skilled in diseases of the eye, that it is the sense of this body that, if requested to do so, the Council of the California Medical Association will appoint a committee to advise with the responsible officials in this state for the

purpose of designating those physician in the state who are ophthalmologists or physicians skilled in diseases of the eye and to advise on any other medical matters that will aid in building up the scientific approach to this matter of granting assistance to the needy blind.

The Secretary of this body is directed to send a copy of this resolution to the state official, commission or department administering blind assistance in this state; and be it further

Resolved, That the delegates of the California Medical Association to the American Medical Association be and hereby are instructed to present this resolution in the House of Delegates of the American Medical Association at its coming meeting.

The resolution submitted by Wilber Swett of San Francisco, relating to the needy blind, the Committee has altered this resolution slightly, so that the phrase, "a physician skilled in diseases of the eye," which occurs in several places in the resolution, shall clearly be a definition of the word "ophthalmologist," and by adding a clause to the end of the resolution giving the delegates of this Association an opportunity to either present this resolution or support a like resolution, as circumstances may require. I will read the additional phrase: "And Be It Resolved, That the delegates of the California Medical Association to the American Medical Association be and are hereby instructed to present this resolution in the House of Delegates of the American Medical Association at its coming meeting, or to support a similar resolution, as circumstances may require." With these slight changes the Committee moves the adoption of the resolution. The definition of the word "ophthalmologist" was discussed by the various members of the House, and Henry J. Ullmann of Santa Barbara moved, seconded by Stanley S. Mentzer of San Francisco, that wherever the words "physician or physicians" appeared in the resolution, the words "must be examined by an ophthalmologist, who is a doctor of medicine skilled in diseases of the eye," be substituted.

On motion of Irving S. Ingber of San Francisco, seconded by Howard Morrow of San Francisco, the resolution as amended was *adopted*.

The next is a resolution introduced by the Council, regarding the formation of a bureau in the Federal Government governing health and medicine. This was approved by the Committee as submitted at the first meeting of the House of Delegates:

Resolution Concerning a National Department of Public Health

WHEREAS, The Board of Trustees of the American Medical Association has promulgated the following policy and principles:

"Recognizing that committees of the Senate and the House of Representatives of the United States Government and a special committee appointed by the President are at this time concerning themselves with the reorganization of government activities with a view to greater efficiency and economy, and recognizing also that the President, in his opening address to Congress, indicated that he would shortly present to the Congress recommendations for such reorganization of governmental activities in the executive branches, and recognizing, moreover, the great desirability that all activities of the Federal Government having to do with the promotion of health and the prevention of disease might, with advantage, be consolidated in one department and under one head, the Board of Trustees of the American Medical Association would recommend that such health activities as now exist be so consolidated in a single department which would not, however, be subservient to any charitable, conservatory or other department interests. The reorganization and consolidation of medical departments need not, under present circumstances, involve any extension or expansion of governmental health activities, but should serve actually to consolidate and thus to eliminate such duplication as exists. It is also the view of the Board of Trustees that the supervision and direction of such medical or health department should be in the hands of a competently trained physician, experienced in executive administration"; and

WHEREAS, The medical profession by reason of its members' medical education, training and experience, is most competent to determine the medical needs and services that are essential to the conservation of the public's health welfare; therefore be it

Resolved, That the California Medical Association endorse the policy and recommendation of the Board of Trustees of the American Medical Association as herein stated; and be it

Resolved, That the Secretary of the California Medical Association is hereby instructed to transmit this resolution to the President of the United States, to the members of the Senate and the House of Representatives of Congress, and to the Board of Trustees of the American Medical Association; and be it

Resolved, That the Chairman of the Council and the Secretary of this Association address a communication to the Senators and Congressmen of California respectfully urging them to support this policy and recommendation.

✓ ✓ ✓

The Committee moves the adoption of the resolution. Seconded by Henry J. Ullmann, and unanimously *carried*.

* * *

(g) *Resolution Regarding Paternalistic Aid*

WHEREAS, The California Medical Association notes with apprehension the recent increasing tendency of a large group of our citizens to shift the responsibility for their present and future welfare upon a willing paternalistic central government; and

WHEREAS, History records that all of the panaceas proposed or attempted for our economic ills have been repeatedly tried in the past and have always failed; and

WHEREAS, The fundamental reason for these repeated failures is the fact that the measures so failing violate nature's age-old immutable law of individual responsibility; now, therefore be it

Resolved, That the California Medical Association urges the people of this state, as well as of the entire nation, to scrutinize most carefully all proposals for social change and to reject everyone that does not embody the fundamental principle of individual responsibility; and be it further

Resolved, That this principle of individual responsibility is peculiarly essential in any plan contemplating the rendering of medical service on an insurance basis.

✓ ✓ ✓

Resolution introduced by L. A. Alesen of Los Angeles, dealing with social changes in medical service and insurance. Although highly sympathetic with the contents of this resolution, the Committee feels that it would be politically inexpedient to publicize such material at this time and, therefore, recommends that the resolution be not adopted.

✓ ✓ ✓

The Chairman of the Committee moved the adoption of the Committee's recommendation that the resolution be not adopted. Seconded by Karl L. Schaupp of San Francisco. Carried. *Resolution defeated*.

* * *

Next is the Council resolution dealing with membership ritual:

Resolution Concerning Procedure in Admission of New Members

WHEREAS, Membership in the constituent units of our medical federation is a valuable and dignified affiliation; and

WHEREAS, Such affiliation should be consummated by means of an impressive ceremony when applicants are admitted to membership; therefore be it

Resolved, That the House of Delegates authorize the Council of the California Medical Association to prepare a suitable procedure and ritual that will convey to the new members the ideals and objectives of our organizational units; and be it

Resolved, That officers of the county societies are requested to observe this induction ceremony whenever new members are admitted to their units.

✓ ✓ ✓

In this resolution the Committee feels that the words "impressive ceremony" and "ritual" are somewhat misleading and, therefore, offers the following substitute resolution, which it is hoped will serve the same purpose:

Resolved, That the House of Delegates authorize the Council of the California Medical Association to prepare a simple form for the induction of the new members into the component county societies.

The Committee moves the adoption of this substitute resolution. Seconded by Wilber Swett of San Francisco. Rising vote taken: 72 ayes. *Substitute resolution adopted*.

* * *

Next is the resolution introduced by the Council amending paragraphs (a) and (b) of Section 6 of Chapter III of the By-Laws, referring to Reference Committees:

Resolution Regarding an Additional Reference Committee at Annual Sessions

Resolved, That paragraphs (a) and (b) of Section 6 of Chapter III of the By-Laws be and they are hereby amended to read as follows:

Section 6 (a) Appointment of Committee on Credentials and Three Reference Committees.

Prior to or at the beginning of an annual session, the Speaker of the House shall appoint from the members thereof the following committees:

1. A Committee on Credentials.
2. A Reference Committee on Reports of Officers and Standing Committees.
3. A Reference Committee on the Report of the Council and the Report of the Secretary-Treasurer.
4. A Reference Committee on Resolutions, Amendments to the Constitution and By-Laws and New and Miscellaneous Business.

(b) Membership of Credentials and Reference Committees.

Each of the aforesaid committees shall consist of three members, the chairman of each to be designated by the Speaker.

The Speaker, the House concurring, shall refer said reports, resolutions, and business to the respective Reference Committees, but may allocate among them any of said reports, resolutions or portions thereof, and other business, to avoid duplication and to expedite the business of the House of Delegates.

* The Reference Committees shall present written reports dealing with and making recommendations on all matters submitted to them. The report of each committee shall be read by its chairman first as a whole, and the House of Delegates shall then act and vote upon the report as a whole or section by section, as it may deem best.

✓ ✓ ✓

The import of this amendment is to expedite the work of the House of Delegates by the allocation by the Speaker of the work of the House of Delegates to various Reference Committees and creates one new Reference Committee.

The Committee notes that this resolution as printed makes no mention of the reports of special committees. Feeling that it was undoubtedly the intention of the author of this resolution to include the words "special committees" in the phrase "Reference Committee on Reports of Officers and Standing Committees," which should undoubtedly read "Officers, Standing and Special Committees," your Committee has inserted the words "and Special Committees," making the sentence read, "A Reference Committee on Reports of Officers, Standing and Special Committees."

✓ ✓ ✓

With this slight change the Committee moves the adoption of the resolution. Seconded by William H. Kiger of Los Angeles, and unanimously *adopted as amended*.

* * *

The next resolution was introduced by Dewey R. Powell of San Joaquin County, and deals with classified telephone listings.

(c) *Resolution Regarding Physicians' Listings in Telephone Directories*

WHEREAS, Several instances have been reported where unqualified men have been listed in the Classified Directory of the telephone company under the heading of Physicians and Surgeons; and

WHEREAS, It is an injustice to the public to have chiropractors, osteopaths, and naturopaths so classified; and

WHEREAS, Protests of local county societies to district officers have been of no avail because of lack of jurisdiction of such local telephone officials; be it therefore

Resolved, That the Secretary of the California Medical Association be instructed to present this matter to the head of the Pacific Telephone and Telegraph Company requesting that a policy be formulated by that company, governing the accurate listing in classified directories of those practicing the healing art, and that appropriate instructions be submitted to their various local managers.

This resolution complains of a matter that has been an irritant in many parts of the State and which undoubtedly needs correction. The telephone directories of the State of California, however, are under the immediate jurisdiction of the Railroad Commission, and the Committee therefore recommends a substitute resolution which it is believed will accomplish the same end, namely, be it

Resolved, That the secretary of the California Medical Association be and hereby is instructed to confer with the Railroad Commission and other authorities to the end that a uniform policy be formulated governing the listing in the classified telephone directories in California of doctors of medicine and other persons practicing the healing art, in order that such practitioners be listed under their true headings.

✓ ✓ ✓

The Committee moves the adoption of the substitute resolution. Seconded by A. E. Anderson of Fresno, and there being no objection the substitute resolution was unanimously *adopted*.

* * *

The next resolution dealing with legislation was introduced by the San Francisco delegation.

(e) *Resolution Concerning California Medical Association Annual Sessions in Legislative Years*

WHEREAS, In each session of the California Legislature there is introduced much legislation of vital interest to the medical profession; and

WHEREAS, Such legislation often is fully developed before the annual session of the California Medical Association, thus preventing its members from being intelligently informed as to the import of such legislation and from basing a proper course of action thereon; therefore be it

Resolved, That in order to correct this anomalous and frequently unfortunate situation, the California Medical Association hold its annual meeting during the second and third week of the legislative session in those years in which the legislature meets.

✓ ✓ ✓

The Committee, with the consent and assistance of the Chairman of the San Francisco delegation, offers the following substitute resolution:

Resolved, That in the years when the California State Legislature is in session, the Council of the California Medical Association shall, if in its judgment it be necessary, call a special meeting of the House of Delegates for the purpose of considering the legislation then pending. If such meeting be called, it shall be called before March 1 in such year.

✓ ✓ ✓

I would like to explain that the Constitution provides that the Council shall fix the time and place of the annual meeting and all other meetings, and that the House of Delegates could not by resolution fix another meeting date. The Committee adds to this resolution the following clause:

Resolved, That the House of Delegates of the California Medical Association, at the 1937 session assembled, hereby empowers the Council of the California Medical Association to employ a liaison secretary during each session of the California State Legislature, if and when the Legislative Committee of the California Medical Association deems it advisable. Under the direction of the Legislative Committee, this secretary shall send as frequently as seems necessary information and instructions regarding legislative matters to the secretary of each component county society. It will be the duty of the secretary of each component society to immediately transmit this information to the members of his society.

✓ ✓ ✓

The Committee recommends the adoption of the substitute resolution. After discussion, John P. Nuttall of Los Angeles, seconded by Charles A. Dukes of Oakland, moved that the resolution be tabled. The Speaker called for a vote and the motion was *tabled*.

* * *

The next resolution is one of appreciation:

Resolution on the Woman's Auxiliary

The California Medical Association is sincerely appreciative of the most valuable and helpful coöperation of the California Woman's Auxiliary to the California Medical Association. With deep interest we note the expand-

ing growth of the Auxiliary and its activities, which are so effectively administered by the officers of the State Auxiliary and its several county branches in the movements that deal with public health welfare and professional service. The California Medical Association is firm in its opinion that the Woman's Auxiliary constitutes one of our Association's most valuable helpmates; therefore be it

Resolved, That the House of Delegates tenders to the Auxiliary its grateful thanks and earnest appreciation of its past activities and urges that every county society take immediate steps to organize an Auxiliary; and be it further

Resolved, That we hereby assure the California Woman's Auxiliary of our desire to coöperate with them in every possible manner in order to enable the Auxiliary to promote its purposes and expand its activities.

✓ ✓ ✓

The Committee moved the adoption of the resolution. Seconded by Charles A. Dukes and Howard Morrow, and unanimously *carried*.

✓ ✓ ✓

The above report was signed:

REFERENCE COMMITTEE ON RESOLUTIONS AND NEW AND MISCELLANEOUS BUSINESS.

By E. J. Best
Henry J. Ullmann
Lowell S. Goin, *Chairman*.

✓ ✓ ✓

On motion of Lowell S. Goin of Los Angeles, seconded by Howard Morrow of San Francisco, the report as a whole, as amended, was *adopted*.

43. Appreciation of Work of Chairman of Legislative Committee.—With the unanimous consent of the House, O. D. Hamlin of Oakland expressed the appreciation of the House and of the Association for the untiring and self-sacrificing efforts of Junius B. Harris, Chairman of the Committee on Public Policy and Legislation, on behalf of the health welfare of the people of California and the medical profession.

The members of the House expressed their appreciation of Doctor Harris's services by a rising vote.

44. Honorary Members.—With the consent of the House and on behalf of the Council, Morton R. Gibbons presented the following resolution regarding honorary members:

Resolved, That the Council be empowered to revise the list of honorary members of this Association, removing therefrom the names of removed and deceased individuals; and be it further

Resolved, That as of May 5, 1937, the honorary members of this Association shall consist of Henry Harris, of San Francisco, and John C. King, of Los Angeles; and be it further

Resolved, That future elections of honorary members shall be in strict accord with the Constitution and By-Laws, which vests the authority in the House of Delegates.

✓ ✓ ✓

The motion of Morton R. Gibbons for adoption of the resolution was seconded by Stanley Mentzer of San Francisco, and unanimously *carried*.

45. Resolution on Committee of Five.—With the consent of the House, Morton R. Gibbons introduced the following resolution on behalf of the Council:

WHEREAS, The California State Board of Public Health as legal sponsors for this commonwealth of Works Progress Administration Project, known as No. 1453, has in its possession what has been called the final report of the California Medical Economic Survey, which report was made under the supervision of one Paul A. Dodd; and

WHEREAS, The California State Board of Public Health, in accordance with instructions of the Works Progress Administration regarding such survey, now proposes to bring to publication and distribution the California Medical Economic Survey in accordance with the Works Progress Administration rules thereon; therefore be it

Resolved, By the California Medical Association, that it go on record as being in full accord with the California

State Board of Public Health to bring to a conclusion this project; and be it further

Resolved, That the Committee of Five be discharged with thanks and that its powers and duties be and they are hereby transferred to the Council, and that the Council be and is hereby authorized and empowered to take all necessary steps and proceedings to fulfill any outstanding obligation of the Association pertaining to the survey.

Discussion was participated in by Rodney Yoell of San Francisco, Karl L. Schaupp of San Francisco, Russell V. Lee of Palo Alto, Alson R. Kilgore of San Francisco, Dewey Powell of Stockton, Loren R. Chandler of San Francisco, and Harry H. Wilson of Los Angeles.

At the conclusion of the discussion the Speaker called for a rising vote. Eighty-nine delegates voted in favor of adoption of the resolution, and four delegates voted against adoption; and the Speaker declared the resolution adopted.

46. Introduction of President.—The Speaker called upon the retiring president, Edward M. Palette to introduce the incoming president, Howard Morrow, to the House. The entire House rose in tribute and respect to Doctor Morrow, who responded, expressing appreciation for the honor conferred upon him and pledging his efforts for the best interests of the Association during the coming year.

47. Presentation of Past President's Certificate.—President Howard Morrow presented Past President Palette with his honorary past president's certificate.

48. Induction of Speaker.—William W. Roblee, retiring speaker, presented Speaker Lowell S. Goin to the House. Doctor Goin responded, expressing his appreciation for the honor and confidence that had been accorded him in election to the office of Speaker, and concluded with the following biblical quotation: "For what doth the Lord require of thee but to keep His commandments, to show mercy, and to walk humbly before Him."

49. Minutes of the Session.—The Secretary reported that there was no unfinished business upon his desk, and that the minutes of this session of the House of Delegates were electrically transcribed. With the approval of the House, the Speaker of the House of Delegates, the Chairman of the Council, and the Secretary, were authorized to edit the minutes of the House for publication.

50. Adjournment.—There being no further business the Speaker declared this session of the House of Delegates to be adjourned, without day, at 1:20 a. m. on Thursday, May 6, 1937.

WILLIAM W. ROBLEE, *Speaker*.
F. C. WARNSHUIS, *Secretary*.

COUNCIL MINUTES

Minutes of the Two Hundred and Fifty-Second Meeting of the Council of the California Medical Association*

Held in Room 723, Hotel Del Monte, Del Monte, California, Sunday, May 2, 1937, at 7:30 p. m.

The meeting was called to order by the chairman, Morton R. Gibbons, with the following members present: President Edward M. Palette; President-Elect Howard Morrow, Speaker William W. Roblee, Chairman of Council Morton R. Gibbons, Chairman of Executive Committee Karl L. Schaupp; Councilors H. J. Ullmann, Calvert Emmons, Carl R. Howson, A. E. Anderson, A. L. Phillips, O. D. Hamlin, C. E. Schoff, H. S. Rogers, H. H. Wilson, W. H. Kiger, J. B. Harris, C. O. Tanner; Charles A. Dukes, Chairman of Public Relations Committee; George H. Kress, Editor; F. C. Warnshuis, Secretary; Mr. Hartley F. Peart, General Counsel; and his associate, Mr. Howard Hassard.

Absent: T. Henshaw Kelly.

* The minutes of the two hundred and fifty-first meeting of the Council of the California Medical Association were printed in the May, 1937, issue of CALIFORNIA AND WESTERN MEDICINE, page 331. Minutes in this series now printed are for the two hundred and fifty-second to the two hundred and fifty-sixth meetings, inclusive.

1. Report of the Auditors.—The annual report of the audit of the funds of the Association were presented and on motion of Councilor Phillips, seconded by Councilor Ullmann, the audit of the Association's books for 1937 as prepared by Ernst & Ernst, certified public accountants, was approved for submission to the House of Delegates. Carried.

2. Standing Committee Reports.—It was moved by Councilor Ullmann, seconded by Councilor Kiger, that the reports of standing and special committees as published in the Pre-Convention Bulletin be approved for submission to the House of Delegates. Carried.

3. Order of Business.—It was moved by Speaker Roblee, seconded by Councilor Phillips, that the order of business for the two meetings of the House of Delegates be approved. Carried.

4. Scientific Exhibit Awards.—The Secretary reported that the Scientific Committee requested that the Council appropriate \$200 for prize awards for the scientific exhibits at annual sessions.

It was moved by Councilor Ullmann, seconded by Councilor Schaupp, that the Council appropriate, with the approval of the Auditing Committee, \$100 as first prize, \$60 as second prize, and \$40 as third prize for the scientific exhibits awarded first, second, and third places by the Committee on Scientific Awards. Carried.

5. Appeals.—The following report, which was approved for inclusion in the report of the Council, was submitted:

The Judicial Council of the American Medical Association has acted upon the following appeals:

April 5, 1937, the Judicial Council, finding no reversible error or injustice in the case, sustained the decision of the Council of this Association in the matter of the appeals of Doctors F. W. Callison, J. L. McClure, Harry W. Davis, George H. Heppner, James P. Pressley, Frank E. Stiles, Edward Melville Talbott, Bertram Stone, Louis Clive Jacobs, and Herbert J. Cohn.

The Judicial Council has also sustained the decision of the Council of this Association, affirming in part orders entered by the Kern County Medical Society against Doctors Joe K. Smith, John M. Kirby, and R. M. Jones.

On motion of Councilor Ullmann, seconded by Councilor Rogers, the Secretary was instructed to include this decision in the minutes of the Council and transmit the same to the secretaries of the county societies involved and that those societies be instructed to apply the decisions as effective as of April 5, 1937. Carried.

6. Council Report.—The report of the Council was read by Chairman Gibbons, and acted upon section by section.

After full discussion the Council recommended to the House of Delegates that the annual dues be set at \$10 per year, and that such recommendation be included in the Council report.

It was moved by Councilor Schaupp, seconded by President-Elect Morrow, that the report of the Council, as amended, be approved. Carried.

7. California Hospital Association.—A letter from the California Hospital Association was read and action at this time was deferred.

8. Committee on Survey of Expenditures.—C. E. Schoff, Chairman of the Committee on Survey of Expenditures, stated that the Committee would be ready to report tomorrow and that it would like further time for the report on publication costs of CALIFORNIA AND WESTERN MEDICINE, and also wanted a clarification of Doctor Kress's wishes as stated in the previous resolution on publication costs adopted by the Council.

It was moved by President Palette, seconded by Councilor Harris, that the matter of printing costs be made a special item of business for the Thursday Council meeting. Carried.

9. Committee of Five.—It was moved by Councilor Kiger, seconded by Councilor Emmons, that the supplemental report of Dr. W. W. Molony, Chairman of the Committee of Five, be filed for future reference. Carried.

10. Amendments to By-Laws.—Councilor Emmons submitted proposed amendments to the By-Laws providing for one additional Reference Committee in the House of Delegates.

It was moved by Councilor Schaupp, seconded by Councilor Harris, that the proposed amendments to Chapter III, Section 6, of the By-Laws be approved for inclusion in the

report of the Council and submission to the House of Delegates. (See House of Delegates minutes.)

11. Financial Statements.—Financial statement for the month of May, 1937, was submitted by the Secretary and approved by the Council.

12. Councilor Kelly.—It was the sense of the Council that a telegram be sent to Councilor T. Henshaw Kelly expressing appreciation of the services rendered by him to the Association and its regret that his professional duties prevent his attendance at this annual session.

13. Venereal Diseases.—A letter from Dr. Russell Lee was presented and on motion of Councilor Rogers, seconded by Councilor Schaupp, was referred to the Chairman of the Council for reply.

It was moved by Editor Kress, seconded by President-Elect Morrow, that the following resolution be adopted:

WHEREAS, The Council of the California Medical Association has expressed its approval of proposed legislation designed to combat and reduce the prevalence of the venereal diseases, syphilis and gonorrhea; and

WHEREAS, Assembly Bill 2790 (Burns) is designed through constituted State authorities, to combat and bring about, as far as possible, the control and elimination of these diseases; now therefore, be it

Resolved, By the Council of the California Medical Association, that it approves in principle the provisions contained in Assembly Bill 2790; and be it further

Resolved, That this resolution be forwarded to the Honorable Speaker of the Assembly and the Lieutenant Governor for the information of the respective Houses.

14. Appeals.—It was moved by Councilor Howson, seconded by Councilor Schaupp, that the representatives of the Association at the hearing of the appeals to the American Medical Association, Doctors C. A. Dukes, Louis A. Packard, and Elbridge Best, be tendered a vote of thanks. Carried.

15. Adjournment.—At this point adjournment of the Council was taken until 2 p. m. Monday, May 3.

MORTON R. GIBBONS, *Chairman*.

F. C. WARNSHUIS, *Secretary*.

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Minutes of the Two Hundred and Fifty-Third Meeting of the Council of the California Medical Association

Held in Room 723, Hotel Del Monte, Del Monte, California, Monday, May 3, 1937, at 2:30 p. m.

The meeting was called to order by the chairman, Morton R. Gibbons, with the following members present: President Edward M. Pallette, President-Elect Howard Morrow, Speaker William W. Roblee; Chairman of the Council, Morton R. Gibbons; Chairman of the Executive Committee, Karl L. Schaupp; Councilors H. J. Ullmann, Calvert Emmons, Carl R. Howson, A. E. Anderson, A. L. Phillips, O. D. Hamlin, C. E. Schoff, Henry S. Rogers, H. H. Wilson, William H. Kiger, J. B. Harris, C. O. Tanner; Chairman of Public Relations Committee Charles A. Dukes; Editor George H. Kress; Secretary F. C. Warnshuis; General Counsel Hartley F. Peart; and his associate, Mr. Howard Hassard.

Absent: T. Henshaw Kelly.

1. Budget for 1938.—Karl L. Schaupp, Chairman of the Auditing Committee, submitted a revised budget for the year 1937 based on an annual assessment of \$10.

It was moved by Councilor Schaupp, seconded by Chairman of Public Relations Committee Dukes, that the budget of Association receipts and expenditures for 1938, as amended, be approved. Carried.

2. County Society Programs.—Doctor Anderson stated that the smaller counties were having difficulties securing speakers for their scientific programs and offered a resolution in relation thereto.

It was moved by Chairman of Public Relations Committee Dukes, seconded by Councilor Anderson, that the resolution be revised and submitted to the Committee on Postgraduate Activities with the recommendation that the Committee take action along these lines. Carried.

3. Standing Committees.—The Chairman stated that he had appointed as members of the Committee to review

the membership of Standing Committees, Doctors W. H. Kiger, Henry Rogers, and Karl L. Schaupp.

4. Legislative Committee.—J. B. Harris, Chairman of the Legislative Committee, submitted a brief report on outstanding legislative bills and stated that a full report would be submitted at the third general meeting. (See minutes of the third general meeting.)

Discussion was had of the proposed vivisection initiative.

5. Minutes.—On motion of President Pallette, seconded by Chairman of Public Relations Committee Dukes, the minutes of the 242nd, 243rd, 244th, 245th, 246th, 247th, 248th, 249th, 250th, and 251st meetings of the Council and the minutes of the 147th, 148, and 149th meetings of the Executive Committee, were approved. Carried.

6. Reinstatement of Delinquent Members.—It was moved by Councilor Phillips, seconded by Councilor Schoff, that all members whose memberships had lapsed on account of nonpayment of dues and whose dues have been remitted since April 1 by the component county societies be reinstated to membership. Carried.

7. Place of Next Annual Session.—After discussion of the place of the next annual session, on motion of Councilor Kiger, seconded by Councilor Hamlin, the Huntington Hotel, Pasadena, was selected as the place of the 1938 annual session. Carried.

The Executive Committee was authorized to fix the time of the next annual session after determination of the date of the American Medical Association and other meetings.

8. Animal Experimentation.—It was moved by President Pallette, seconded by Councilor Rogers, that the Chairman of the Council appoint a Committee of Three, to determine legislative policies concerned with animal experimentation. Carried.

9. Retired Membership.—The Secretary presented membership data and requests for retired memberships from Albert J. Houston, Asa W. Collins, Ellis Harbert, and Leonard Ely.

It was moved by Councilor Emmons, seconded by Chairman of Public Relations Committee Dukes, that Albert J. Houston, San Francisco, Asa W. Collins, San Francisco, Ellis Harbert, Stockton, and Leonard W. Ely, Palo Alto, be granted retired membership in the California Medical Association. Carried.

10. Indemnity Defense Fund Trustee.—On nomination duly made and ballot duly cast, Howard Morrow, San Francisco, was reelected trustee of the Indemnity Defense Fund for a term of three years, term expiring January 1, 1940.

11. Adjournment.—There being no further business, the meeting adjourned to meet at 9 a. m. Tuesday, May 4.

MORTON R. GIBBONS, *Chairman*.

F. C. WARNSHUIS, *Secretary*.

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Minutes of the Two Hundred and Fifty-Fourth Meeting of the Council of the California Medical Association

Held in Room 723, Hotel Del Monte, Del Monte, California, Tuesday, May 4, 1937, at 9 a. m.

1. Call to Order and Adjournment.—The meeting was called to order by the chairman, Morton R. Gibbons, and there being no business that demanded immediate action, adjournment was taken until 9 a. m. Wednesday, May 5.

MORTON R. GIBBONS, *Chairman*.

F. C. WARNSHUIS, *Secretary*.

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Minutes of the Two Hundred and Fifty-Fifth Meeting of the Council of the California Medical Association

Held in Room 723, Hotel Del Monte, Del Monte, California, Wednesday, May 5, 1937, at 9 a. m.

The meeting was called to order by the chairman, Morton R. Gibbons, with the following members present: President Edward M. Pallette, President-Elect Howard Morrow, Speaker William W. Roblee; Chairman of the Council, Morton R. Gibbons; Chairman of the Executive Com-

mittee, Karl L. Schaupp; Councilors H. J. Ullmann, Calvert Emmons, Carl R. Howson, A. E. Anderson, A. L. Phillips, O. D. Hamlin, C. E. Schoff, H. S. Rogers, H. H. Wilson, William H. Kiger, J. B. Harris, C. O. Tanner; C. A. Dukes, Chairman of Public Relations Committee; George H. Kress, Editor; F. C. Warnshuis, Secretary; Mr. Hartley F. Peart, General Counsel; and his associate, Mr. Howard Hassard.

Absent: T. Henshaw Kelly.

1. Golden Gate International Exposition.—A letter from Mr. Leland V. Cutler, President of the Golden Gate International Exposition, was read and the Secretary was instructed to reply thereto. Doctor Gibbons announced that Mr. Sandusky and Mr. Milton Silverman, publicity representatives of the Exposition, were desirous of addressing the Council regarding coöperation with the California Medical Association in promoting a Hall of Health, Science and Education. With the permission of the Council, Mr. Sandusky and Mr. Silverman then outlined the plans of the Exposition to the Council. It was requested that the California Medical Association appoint an advisory committee to work with the Exposition Committee and confer with other committees for the purpose of securing outstanding types of commercial exhibits from industrial firms; to assist in censorship and advise on applications for space and exhibition of products.

The Chairman of the Council was instructed to appoint a committee to coöperate with the Golden Gate International Exposition.

2. Committee of Five.—William R. Molony, Chairman of the Committee of Five, reported on the present status of the report of the Committee of Five. Doctors A. R. Kilgore and Rodney Yoell, members of the Committee of Five, then discussed the report.

It was moved by Councilor Schaupp, seconded by Councilor Anderson that the Council instruct the Committee of Five to proceed with whatever measures or steps may be necessary to secure this report and the prevention of its unauthorized publication by Doctor Dodd or any other unauthorized person, after consultation with the legal department.

After discussion, on motion of Councilor Schaupp, seconded by Councilor Ullmann, the motion was tabled until the afternoon meeting of the Council. Carried.

3. Standing Committees.—William H. Kiger, Chairman of the Committee on Review of Standing Committee appointments, submitted the following recommendations which were approved by the Council for submission to the House of Delegates:

Lemuel P. Adams of Oakland reelected as member of Scientific Committee.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

John V. Barrow (Chairman), Los Angeles.....	1940
Edwin L. Bruck, San Francisco.....	1938
William H. Geistweit, San Diego.....	1939

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

B. W. Black, Oakland.....	1940
Fred B. Clarke (Chairman), Long Beach.....	1938
W. R. P. Clark, San Francisco.....	1939

COMMITTEE ON HISTORY AND OBITUARIES

A. E. Belt, Los Angeles.....	1940
F. R. Makinson (Chairman), Oakland.....	1938
J. Marion Read, San Francisco.....	1939
The Secretary ex officio	
The Editor ex officio	

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Karl L. Schaupp, San Francisco.....	1940
George Dawson, Napa.....	1938
Daniel Crosby (Chairman), Oakland.....	1939

COMMITTEE ON INDUSTRIAL PRACTICE

Harry E. Zaiser, Orange.....	1940
Morton R. Gibbons, Sr. (Chairman), San Francisco.....	1938
Philip Stephens, Los Angeles.....	1939

COMMITTEE ON MEDICAL DEFENSE

John P. Nuttall, Santa Monica.....	1940
George G. Reinle (Chairman), Oakland.....	1938
Fred R. DeLappe, Modesto.....	1939

COMMITTEE ON MEDICAL ECONOMICS

Percy Magan, Los Angeles.....	1940
John H. Graves (Chairman), San Francisco.....	1938
William R. Molony, Sr., Los Angeles.....	1939

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

John B. Doyle, Los Angeles.....	1940
B. O. Raulston, Los Angeles.....	1938
Loren R. Chandler (Chairman), San Francisco.....	1939

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

G. Dan Delprat, San Francisco.....	1940
E. Vincent Askey (Chairman), Los Angeles.....	1938
Dewey R. Powell, Stockton.....	1939

COMMITTEE ON POSTGRADUATE ACTIVITIES

John C. Ruddock (Chairman), Los Angeles.....	1940
F. E. Clough, San Bernardino.....	1938
F. F. Gundrum, Sacramento.....	1939
Secretary ex officio	

COMMITTEE ON PUBLICATIONS

Ralph Eusden (Chairman), Long Beach.....	1940
Ruggles A. Cushman, Talmage.....	1938
Oscar Reiss, Los Angeles.....	1939
The Secretary ex officio	
The Editor ex officio	

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

E. T. Remmen, Glendale.....	1940
J. B. Harris (Chairman), Sacramento.....	1938
T. Henshaw Kelly, San Francisco.....	1939

4. Commercial Exhibits.—The Secretary reported on thefts of commercial exhibits during the present session and on motion of Councilor Phillips, seconded by Councilor Kiger, the Chairman of the Council and the President were requested to accompany the Secretary on a visit of these exhibitors. Carried.

5. Recess.—At this point a recess of the Council was declared until 1:30 p. m.

6. Call to Order.—The Council was called to order by the Chairman, with the following members present: Doctors Palette, Morrow, Roblee, Gibbons, Schaupp, Ullmann, Emmons, Howson, Anderson, Phillips, Hamlin, Schoff, Rogers, Wilson, Kiger, Harris, Tanner, Dukes, Kress, Warnshuis, Mr. Peart and Mr. Hassard.

7. American Psychiatric Society.—The Secretary presented a letter from the Committee representing the Section on Neuropsychiatry requesting that an invitation be extended to the American Psychiatric Society to hold its 1938 annual meeting on the Pacific Coast, and on motion of Chairman of Public Relations Committee Dukes, seconded by Councilor Hamlin, the Secretary was authorized to extend a formal invitation by wire to the American Psychiatric Society to hold its 1938 annual meeting in California. Carried.

8. Refund of Dues.—It was moved by Councilor Ullmann, seconded by Councilor Anderson, that the request of the San Luis Obispo County Society for the refunding to the widow of a deceased member of annual dues paid, be granted. Carried.

9. Cultists.—After discussion of the question of consultations of doctors of medicine with cultists and appointments of such cultists to hospital staffs, it was moved by Councilor Ullmann, seconded by Chairman of Public Relations Committee Dukes, that the matter be referred to the Executive Committee for study and report to the Council. Carried.

10. Nurses' Advisory Committee.—It was moved by Councilor Emmons, seconded by Councilor Rogers, that Carl R. Howson of Los Angeles be appointed as the Association's representative on the Advisory Committee to the Chief of the Bureau of Registration of Nurses. Carried.

11. Membership.—A letter from the American Medical Association advising Doctors Ross and Loos that, in view of the outcome of the appeals to the Judicial Council, their fellowships in the American Medical Association had not lapsed and their names were restored to the Fellowship Roster was presented.

It was requested that similar action be recorded in the records of the California Medical Association.

12. **Editor.**—A letter from the southern delegation commending the Editor was presented for the information of the Council.

13. **W. Chalmers-Francis.**—It was moved by Chairman of Public Relations Committee Dukes, seconded by Councilor Tanner, that the Association absorb the balance of \$79 due from the Anesthetists' Association and consider the matter closed. Carried.

14. **Cancer Commission.**—Doctor Morrow, incoming president, announced that he had reappointed as members of the Cancer Commission, Charles A. Dukes, Lyell C. Kinney, and A. R. Kilgore. The appointments were approved by the Council for submission to the House of Delegates.

15. **Scientific Committee.**—In accordance with Section 8, Chapter V, of the By-Laws, and on nomination of Chairman of Public Relations Committee Dukes, seconded by Councilor Tanner, Dr. Lemuel P. Adams of Oakland was reelected as a member of the Committee on Scientific Work.

16. **Honorary Membership.**—After full discussion and consideration, it was moved by Editor Kress, seconded by Councilor Rogers, that the following resolution be submitted to the House of Delegates:

Resolved, That the Council be empowered to revise the list of honorary members of this Association, removing therefrom the names of removed and deceased individuals; and be it further

Resolved, That, as of May 5, 1937, the honorary members of this Association shall consist of Henry Harris of San Francisco and John C. King of Los Angeles; and be it further

Resolved, That future elections of honorary members shall be in strict accord with the Constitution and By-Laws, which vests this authority in the House of Delegates.

17. **Committee of Five.**—It was moved by Councilor Ullmann, seconded by Councilor Wilson, that motion of Councilor Schaupp and the report of the Committee of Five be taken from the table. Carried.

After full discussion, with the consent of the Council Doctor Schaupp withdrew the motion made at the morning meeting of the Council, and on motion of Councilor Ullmann, seconded by Chairman of Public Relations Committee Dukes, the following resolution was adopted for submission to the House of Delegates:

WHEREAS, The California State Board of Public Health as legal sponsors for the commonwealth of Works Progress Administration Project, known as No. 1453, has in its possession what has been called the final report of the California Medical Economic Survey, which report was made under the supervision of one Paul A. Dodd; and

WHEREAS, The California State Board of Public Health, in accordance with instructions of the Works Progress Administration regarding such survey, now proposes to bring to publication and distribution the California Medical Economic Survey, in accordance with the Works Progress Administration rules thereon; therefore, be it

Resolved, By the California Medical Association, that it go on record as being in full accord with the California State Board of Public Health to bring to a conclusion this project; and be it further

Resolved, That the Committee of Five be discharged with thanks, and that its powers and duties be and they are hereby transferred to the Council, and that the Council be and is hereby authorized and empowered to take all necessary steps and proceedings to fulfill any outstanding obligation of the Association pertaining to the survey.

18. **House of Delegates Minutes.**—It was moved by President Pallette, seconded by Councilor Wilson, that the Editor, the Secretary, and the Chairman of the Council be constituted a committee to edit the minutes of the House of Delegates and that such minutes be in condensed form. Carried.

It was moved by President Pallette, seconded by Councilor Emmons, that in publishing the minutes of the House of Delegates, the Committee on Public Relations, and the Executive Committee, they be published in condensed form.

19. **Publicity.**—It was moved by Editor Kress, seconded by Councilor Ullmann, that the Secretary and the Editor secure the names of newspapermen who will be willing to write press comments on articles in CALIFORNIA AND WESTERN MEDICINE and that they be furnished with complimentary copies of the JOURNAL. Carried.

20. **Malpractice Insurance.**—The General Counsel discussed the hearing before the American Bar Association on the corporate practice of law by state medical associations in regard to furnishing of malpractice insurance. Mr. Peart stated that there was no Association activity in this regard in California.

21. **Minimum Wage.**—It was the sense of the Council that the General Counsel furnish information on minimum wage laws for publication in the JOURNAL.

22. **Committee on Association Expenditures.**—C. E. Schoff, Chairman of the Committee on Association Expenditures, read the revised report of the Committee on Publication Costs of CALIFORNIA AND WESTERN MEDICINE and on motion of Councilor Schaupp, seconded by Councilor Kiger, the revised instructions as contained in the report re publication costs were approved.

Doctor Schoff then read the report of the Committee as related to employees of the Association.

It was agreed that the entire report would be sent to each member of the Council for consideration and placed on the docket of the next meeting of the Council.

23. **Intercoast Rider.**—The General Counsel reported that new policy forms had been issued by the Intercoast Hospitalization Insurance Company embodying the principles contained in the rider approved by the Council since the rider form was not acceptable to the Insurance Commissioner.

24. **Woman's Auxiliary.**—On motion of Speaker Roblee, seconded by Councilor Schaupp, \$200 was included in the budget for the Woman's Auxiliary. Carried.

25. **Financial Statement.**—Financial statement for the month of April, 1937, was presented and approved by the Council.

26. **Committee of Five.**—It was moved by Councilor Ullmann, seconded by President Pallette, that the Secretary be authorized to open the report of the Committee of Five and have a sufficient number of copies made, furnishing three copies to the Board of Health. Carried.

It was moved by Speaker Roblee, seconded by President Pallette, that a copy of the report of the Committee of Five be furnished to Dr. A. R. Kilgore for review and revision by him and that the Council designate Doctor Kilgore as liaison representative to the Board of Health.

27. **Adjournment.**—There being no further business, the Council adjourned to meet at 9 a. m. Thursday.

MORTON R. GIBBONS, *Chairman*.

F. C. WARNSHUIS, *Secretary*.

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Minutes of the Two Hundred and Fifty-Sixth Meeting of the Council of the California Medical Association

Held in Room 723, Hotel Del Monte, Del Monte, California, Thursday, May 6, 1937, at 9 a. m.

The meeting was called to order by Acting Chairman Morton R. Gibbons, with the following members present: Past President Edward M. Pallette, President Howard Morrow, President-Elect William Roblee, Speaker Lowell Goin, Acting Chairman of Council Morton R. Gibbons; Councilors Karl L. Schaupp, Calvert Emmons, A. E. Anderson, A. L. Phillips, C. Howson, O. D. Hamlin, C. E. Schoff, H. S. Rogers, H. H. Wilson, J. B. Harris, C. O. Tanner; C. A. Dukes, Chairman of Public Relations Committee; George H. Kress, Editor; F. C. Warnshuis, Secretary; and Mr. Hartley F. Peart, General Counsel.

Absent: Councilors T. Henshaw Kelly and Louis Packard.

1. **Committee on Public Relations.**—The Acting Chairman announced that by virtue of his election as chairman of the Committee on Public Relations, Dr. Charles A. Dukes was a member of the Council for the ensuing year.

2. **Election of Chairman.**—On nomination duly made and ballot duly cast, Morton R. Gibbons was elected chairman of the Council for the ensuing year.

3. **Papers for Official Journal.**—Correspondence from Harold Brunn, M. D., re publication of papers of undergraduate students of the University of California was presented and on motion of Councilor Kiger, seconded by Chairman of Public Relations Committee Dukes, full juris-

diction in the matter was left in the hands of the Editor. Carried.

4. Fall Meeting of the Council.—It was moved by Chairman of Public Relations Committee Dukes, seconded by Councilor Kiger, that the determination of the date of the fall meeting of the Council be left to the Executive Committee. Carried.

5. Woman's Auxiliary.—It was moved by Chairman of Public Relations Committee Dukes, seconded by Councilor Anderson, that the Chairman of the Council be directed to write to the Woman's Auxiliary, expressing the desire of the Council to cooperate with them in every way and stating that if they will indicate their wishes we shall be glad to carry them out as far as possible and that we shall also be glad to consult with them regarding their arrangements for meetings, etc. Carried.

It was suggested that a letter be written to the women in San Bernardino County, encouraging them to organize an auxiliary.

6. Committee of Five.—It was moved by Councilor Wilson, seconded by Councilor Emmons, that the moneys allocated in the budget to the Committee of Five (California Medical Economic Survey) be returned to the general fund for use by the Council in order to carry out the purport of the resolution adopted by the House of Delegates in relation to the report of the Committee of Five. Carried.

7. Election of Vice-Chairman.—On nomination of Chairman of Public Relations Committee Dukes, seconded by Councilor Anderson, and on ballot duly cast, Junius B. Harris was elected vice-chairman of the Council for the ensuing year.

8. Executive Session.—At this point the Council went into executive session. At the close of the executive session the Council again proceeded with elections.

9. Election of Secretary-Treasurer.—On nomination of Chairman of Public Relations Committee Dukes, duly seconded, and on ballot duly cast, F. C. Warnshuis was elected secretary-treasurer of the Association at the same salary on a month-to-month basis.

10. Election of Editor.—On nomination of Councilor Kiger, duly seconded, and on ballot duly cast, George H. Kress was elected editor of the JOURNAL at the same salary on a month-to-month basis.

11. Appointment of Counsel.—On motion duly made, seconded and carried, Hartley F. Peart was appointed General Counsel of the Association at the same retainer for the ensuing year.

On motion duly made, seconded and carried, Hubert Morrow of Los Angeles was appointed associate counsel for the ensuing year, without retainer.

12. Committee of Five Report.—It was moved by Past President Pallette, seconded by Councilor Phillips, that the matter of publication and other matters in connection with the report of the Committee of Five (California Medical Economic Survey) be delegated to the Executive Committee with full power to act in any emergencies. Carried.

13. Legislation.—It was moved by Councilor Schaupp, seconded by Chairman of Public Relations Committee Dukes, that the Lieutenant-Governor and members of the Legislature who have rendered valuable service to the health welfare of the State be commended. Carried.

14. Auditing Committee.—The Chairman of the Council announced that he had appointed as members of the Auditing Committee, Doctors Karl L. Schaupp (chairman), T. Henshaw Kelly, and O. D. Hamlin. The appointments were approved by the Council.

15. Delegates to the American Medical Association. Dr. William H. Kiger resigned as alternate to Dr. Edward M. Pallette. On nomination of Chairman of Public Relations Committee Dukes, seconded by Kiger, Harry H. Wilson was elected alternate to the American Medical Association meeting of the House of Delegates, to take the place of Dr. William H. Kiger.

16. Appreciation.—On motion of Past President Pallette, seconded by all the Councilors, the Secretary was instructed to address a communication to Mr. Carl Stanley, Mr. Head, Mr. Huckins, and Mr. Parker of the Hotel Del Monte, conveying to them the thanks and grateful appreci-

ation of the officers, Council, and members for all the courtesies and cooperation that they had extended during the annual session for the pleasure and comfort of all in attendance. Carried unanimously.

17. Adjournment.—There being no further business the meeting adjourned.

MORTON R. GIBBONS, *Chairman.*

F. C. WARNSHUIS, *Secretary.*

DIGEST OF MINUTES OF ONE HUNDRED AND FIFTY-FIRST MEETING OF THE EXECUTIVE COMMITTEE

Held in the offices of the Association, San Francisco, May 29, 1937.

Members Present.—President-Elect William W. Roblee; Speaker Lowell S. Goin; Chairman of the Council, Morton R. Gibbons; Chairman of the Auditing Committee, Karl L. Schaupp; Chairman of the Public Relations Committee, Charles A. Dukes; Editor George H. Kress; Secretary F. C. Warnshuis; General Counsel Hartley F. Peart and his associate, Mr. Howard Hassard.

Members Absent.—President Howard Morrow and Past President Edward M. Pallette.

1. Election of Chairman.—Karl L. Schaupp of San Francisco was elected chairman for the ensuing year.

2. Annual Experimentation.—The following Committee on Policy and Education was appointed: Philip K. Gilman (chairman), Charles A. Dukes, and Loren R. Chandler. The following constitute an advisory committee: Deans of the four medical colleges, President of the State Board of Health, Director of the Hooper Foundation, and Dr. J. C. Geiger of San Francisco.

3. Staffs of Hospitals.—The following committee was appointed to review the question of irregular practitioners, their relation to private hospitals, and consultations: Lowell S. Goin (chairman), W. W. Roblee, Benjamin W. Black, Dewey Powell, Glenn Myers, J. B. Harris, and George H. Kress.

4. Medical Economic Survey.—Letter from Paul A. Dodd was read, and letter and reply were ordered published.

University of California at Los Angeles,

May 26, 1937.

Dr. Frederick C. Warnshuis,
Secretary, California Medical Association,
450 Sutter Street,
San Francisco, California.

Dear Doctor Warnshuis:

In the absence of any official notification, I take this opportunity to seek information concerning final action of the California Medical Association and/or the State Department of Public Health relative to plans for the publication and release of the California Medico-Economic Survey.

Will you kindly inform me at your earliest convenience as to the present status of this question, and also as to what official final stand the California Medical Association committed itself to at its recent conference in Del Monte? In the absence of any reply to this simple inquiry on or before June 5, 1937, it will be my understanding that no action has been taken and that those interested are free to complete plans for a private publication of the final report. Will you, therefore, kindly advise me accordingly if this is not the case?

Sincerely yours,

(Signed) PAUL A. DODD.

cc—to Members of the Committee of Five,
Members of the Advisory Committee.

✓ ✓ ✓

Four Fifty Sutter, San Francisco,

May 27, 1937.

Professor Paul A. Dodd,
University of California at Los Angeles,
405 Hillgard Avenue,
Los Angeles, California.

Dear Professor Dodd:

Acknowledgment is made of your letter sent by registered mail, May 26, 1937.

Dr. Morton R. Gibbons, Chairman of the Council and Dr. Howard Morrow, President of this Association and of the State Board of Health, asked me to transmit the following information to you:

1. On Wednesday, May 5, 1937, the House of Delegates of the California Medical Association discharged the Association's "Committee of Five."

2. The House of Delegates authorized the Council, through its Executive Committee, to take over all the responsibilities of the Committee of Five and to fulfill any outstanding obligations of the Association pertaining to the survey.

3. The Council of this Association was also authorized and empowered to take all necessary steps and procedures to join with the State Board of Health, the sponsors of the survey, and bring it to publication and distribution in accordance with the rules and the directions of the Works Progress Administration.

4. The State Board of Health is proceeding in accordance with the instructions of the Director of Projects of the Works Progress Administration.

5. On May 4 or 5, the Committee of Five, through its chairman, Dr. W. R. Molony, wired you the committee's position.

6. This Association, therefore, holds that your responsibilities in connection with this survey are terminated and that the responsibilities for the final disposition and publication of this report now lies with the State Board of Health and the Director of Projects of the Works Progress Administration.

It should, therefore, be your definite understanding that you are without authority to seek to attain publication through "private plans" as this concluding function rests solely with the Board of Health and the Federal Government through its Projects Director. It is expected that you will conform to this federal rule and instruction.

Sincerely yours,

MORTON R. GIBBONS, M. D.,
Chairman of the Council.

HOWARD MORROW, M. D.,
President of the Association.

Attest: F. C. Warnshuis, M. D.,
Secretary.

5. **Resettlement Administration.**—This matter was referred to Chairman Gibbons, President Morrow, and Secretary Warnshuis.

6. **Annual Meeting Expense.**—Secretary Warnshuis reported a profit of \$2,919.57 over all expenses.

7. **Delegate to the American Medical Association.**—W. W. Roblee was elected as a delegate from California to serve in place of Fred B. Clarke and A. J. Scott, alternate, unable to serve.

8. **Teletype.**—Future use was referred to the Chairman of the Council and the Executive Committee.

9. **Fall Conference of County Secretaries, Council, and Standing Committees.**—This was set, subject to subsequent final Council approval, for October 30 and 31, 1937, at Fresno, California.

10. **San Francisco Golden Gate Committee.**—The following committee was appointed: T. Henshaw Kelly (chairman), Edward M. Palette, C. A. Dukes, F. C. Warnshuis, and Hartley F. Peart. The Committee was authorized to appoint subadvisory committees.

11. **Senate Bill 118.**—The Chairman was instructed to review Senate Bill 118 and initiate indicated Association action.

12. **Resignation.**—The resignation of Councilor Charles E. Schoff was referred to the fall Council meeting.

13. **Council on Pharmacy and Chemistry.**—Reaffirmation was recorded in regard to the Association's adherence to the rules relating to therapeutic preparations advertised in CALIFORNIA AND WESTERN MEDICINE.

14. **History.**—An appropriation of \$100 was made to establish a Revolving Fund for the Committee on History and Obituaries to purchase and reproduce photographs for Association records.

15. **Farm Bureau Magazine Article.**—This was referred to the fall Council meeting.

16. **Telephone Listing.**—Secretary Warnshuis was instructed to proceed in accordance with the resolution adopted in Del Monte.

17. **Routine.**—Routine matters were considered and indicated action recorded.

18. **Adjournment.**—Meeting adjourned at 12:45 p. m.

KARL L. SCHAUPP, *Chairman.*
F. C. WARNSHUIS, *Secretary.*

HEALTH INSURANCE LEGISLATION: IMPORTANT MESSAGE FROM THE C. M. A. COMMITTEE ON PUBLIC POLICY AND LEGISLATION

To Officers, Councilors, and County Society Secretaries.

Dr. Junius B. Harris, Chairman of the Committee on Legislation and Public Policy, has requested that the following be transmitted to officers, councilors, and county society secretaries for their information:

BULLETIN

There will be no legislation adopted on health insurance at the present session of the California Legislature. In order that our members may all fully understand the situation, I will transmit the following information to members of our Association.

For the past two years, certain groups now engaged in rendering medical and hospital service on a group basis, have been actively campaigning for legislation to legalize such service under the regulation of the Insurance Commissioner. In their efforts they enlisted the active support of the California Farm Bureau Federation, the California Firemen's Association, and many groups of city and county employees, teachers' groups, etc. On January 14, 1937, they caused to be introduced Senate Bill 121 by Senator Williams, and on January 20 an identical measure, Assembly Bill 1283, by Assemblyman Welsh.

During this same period the California Medical Association, through special committees, studied the subject of voluntary health insurance and were convinced that a determined and possibly successful effort would be made to pass some legislation along that line at the present session of the Legislature, caused to be introduced on January 21, 1937, Senate Bill 605 by Senator McGovern and an identical measure, Assembly Bill 1491, by Assemblymen Boyle, Cronin, and McMurray.

Proponents of this legislation elected to press their case in the Assembly through Assembly Bill 1283 (Welsh) and we met them squarely with our Assembly Bill 1491 (Boyle, Cronin, and McMurray). This was one of the most hotly contested issues of the Legislature. For four weeks the battle raged in the Committee on Insurance with the Farm Bureau groups in the front ranks insisting upon passage of Assembly Bill 1283 (Welsh). We were equally aggressive in opposing this measure and pushing our own Assembly Bill 1491 as a bill giving better protection to the public. During the many arguments we were repeatedly charged with insincerity; the California Medical Association was attacked as simply trying to befog the issue and kill all health insurance bills. We stood by our guns; amended our bill to meet expressed wishes of the Committee on Insurance and stood determined to fight for what we deemed proper protection of the public in any health insurance bill that might be passed. This Committee sent both bills 1283 and 1491 to the floor of the Assembly with "do pass" recommendations on April 23.

Assembly Bill 1283 came before the Assembly for vote on May 10. Through splendid cooperation in informing assemblymen as to the bad features of this bill, it was defeated 24 to 46. The assemblymen were promised that a better bill would be forthcoming in Assembly Bill 1491. However, Mr. Welsh immediately gave notice of reconsideration of the vote by which Assembly Bill 1283 had been defeated, thus keeping it alive for his emergencies.

The Ways and Means Committee of the Assembly insisted that if Assembly Bill 1491 were to pass, it must contain an appropriation of funds to carry out its proposals. The appropriation feature would have required fifty-four votes for passage as compared with forty-one votes on an ordinary bill.

All county societies and many individual physicians responded nobly to our calls for help in our efforts to pass this bill, but late Friday afternoon we were convinced that we could not pass the measure in the form approved by your Committee on Legislation and Public Policy. We were advised that eleven amendments would be submitted to weaken and destroy some of its basic principles. If these were adopted, our bill would not be acceptable to its sponsors. If we failed to pass our bill, the sponsors of Assembly Bill 1283 would again press its passage with probable chances of success, basing their arguments on the plea that

there is a public demand for some regulatory legislation to control alleged irresponsible outfits offering health service. Many of our most ardent supporters were under terrific pressure from farm and local groups, based, we believe, on a lack of understanding of the merits of our proposal as outlined in Assembly Bill 1491 as submitted through Assemblymen Boyle, Cronin, and McMurray.

Within a few moments of the time for consideration of our bill, the author of Assembly Bill 1283 proposed that he would drop his bill with its motion for reconsideration and suggest no hasty legislation be enacted at this session, but that the subject be further considered in 1939. He asked authors of our bill to join him in dropping the issue and suggesting the appointment of a committee to draft a bill for the 1939 Legislature. Not to study or investigate the issue, but merely to draft a bill. He further stated that he was willing to prepare and insert, and did prepare and insert, in the journal of the Assembly a signed statement to the effect that his previous charges of insincerity on the part of the California Medical Association were erroneous and that he is now of the opinion we "were actuated by the highest motives, and an honest and sincere desire to furnish to the people of the State an adequate low-priced health and medical service."

After consultation with authors of our bill, our legal counsel and competent legislative observers, your Committee agreed to this course and both bills were dropped at a late hour Saturday night, May 22.

We wish to express our appreciation to Senator McGovern; Assemblymen Boyle, Cronin, and McMurray, authors of our bill; Assemblymen Johnson, Garibaldi, and Sawallisch, who assisted in the floor fight against Assembly Bill 1283; and to Assemblyman Peek, who acted very fairly as chairman of a subcommittee which considered both bills. A measure that we felt was inadequate in its protection of the public was defeated; we made a sincere effort to enact what we felt would be a forward step in health insurance legislation, but could not muster the necessary fifty-four votes.

Many of the assemblymen from districts to which this bulletin is being sent were firm in their support of your bill. Will you please express to them personally our appreciation of their assistance, and fully advise all of your members of this splendid coöperation.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

J. B. Harris, M. D., *Chairman*

T. Henshaw Kelly, M. D.

E. T. Remmen, M. D.

THE PUBLIC HEALTH LEAGUE OF CALIFORNIA

By Ben H. Read, *Executive Secretary*

COMMENT

SIXTY-SIXTH ANNUAL SESSION

At noon on May 6, with the final adjournment of the Sections on Medicine, Surgery, and Eye, Ear, Nose and Throat, the Association's 1937 session passed into the historical archives of the Association.

Held in Del Monte—that holds so many memories of former annual sessions—with an attendance registration of 1,420, with a scientific program that was characteristic of scientific progress, with guest speakers who justified their selection by reason of their national prominence, with social opportunities that were inductive to cementing bonds of fraternal fellowship—this sixty-sixth session was an outstanding one in the Association's history.

It was gratifying to hear the many, many expressions of commendation and approval from those in attendance. There was a unanimous attitude that all were well repaid for the time spent in Del Monte.

The two sessions of the House of Delegates were characterized by the diligence and earnestness of the delegates in the transaction of the business of the Association. The principal enactments were:

1. Discharge of the Committee of Five and delegating to the Executive Committee of the Council the work of closing the activities of that committee.

2. Making the retiring president a member of the Council for one year.

3. Providing for a scientific exhibit at each annual session.

4. Establishing a definite program for postgraduate courses.

5. Providing for an annual joint conference of county secretaries and standing committees in October of each year.

6. Creating an additional reference committee for the House of Delegates.

7. Fixing Association dues for 1938 at \$10—a reduction of \$5.

8. Passing a resolution endorsing the policy of the American Medical Association trustees relating to a medical man as chief head of all federal health activities.

9. Endorsing a qualifying certificate initiative.

10. Authorized establishment of a film library for public health education.

The following officers were elected: President-Elect, W. W. Roblee, Riverside; Speaker, Lowell S. Goin, Los Angeles; Vice-Speaker, John H. Graves, San Francisco; Councilors-at-Large, Junius B. Harris of Sacramento and William H. Kiger of Los Angeles; Councilor, Third District, Louis A. Packard, Bakersfield; Councilor, Sixth District, Karl L. Schaupp, San Francisco; Councilor, Ninth District, Henry S. Rogers, Petaluma. Delegates to the American Medical Association: Elbridge J. Best of San Francisco, Lyell C. Kinney of San Diego, and J. P. Nuttall of Los Angeles. Alternates to the American Medical Association: Robert S. Stone of San Francisco, Bon O. Adams of Riverside, and F. M. Pottenger, Sr., of Los Angeles.

Pasadena was selected as the place for the 1938 annual session.

Committee appointments for standing committees will be found in the forepart of each issue of this journal.

The course is set for another year of Association activity, a year that will evidence sustained activity to enhance the interests of all members and to fulfill our organization's purposes and objectives.

DEL MONTE SCIENTIFIC PROGRAM

The Scientific Committee and the Section Officers are to be congratulated for a most interesting, instructive scientific program. This was attested by the sustained interest and large attendance at all section and general meetings. It is impossible to summarize the papers and presentations. A goodly proportion will be published during the year.

At the general meetings our invited guests justified their selection by the scientific and practical presentation of their subjects. Our appreciation and thanks are extended to Doctors Cyrus Sturgis and Norman Miller of the University of Michigan; Henry Alsop Riley of Columbia University and Jesse G. M. Bullowa of the New York University College of Medicine.

The following Section officers were elected:

Anesthesiology Section—Chairman, W. L. Garth of San Diego; Secretary, John G. Dunlop of Los Angeles.

Dermatology Section—Chairman, Stanley O. Chambers of Los Angeles; Vice-Chairman, Arne Ingels of San Francisco; Secretary, Nelson Paul Anderson of Los Angeles.

Eye, Ear, Nose and Throat Section—Chairman, Frank Baxter of Oakland; Vice-Chairman, Dewey R. Powell of Stockton; Secretary, Clifford B. Walker of Los Angeles.

General Medicine Section—Chairman, Edwin L. Bruck of San Francisco; Secretary, Howard F. West of Los Angeles.

General Surgery Section—Chairman, Harlan Shoemaker of Los Angeles; Secretary, Nelson J. Howard of San Francisco; Assistant Secretary, Ray B. McCarty of Riverside.

Industrial Medicine and Surgery Section—Chairman, Frederick C. Bost of San Francisco; Vice-Chairman, H. G. McNeil of Los Angeles; Secretary, George H. Sanderson of Stockton.

Neuropsychiatry Section—Chairman, Fred O. Butler of Eldridge; Secretary, John B. Doyle of Los Angeles.

Obstetrics and Gynecology Section—Chairman, R. Glenn Craig of San Francisco; Vice-Chairman, George W. Coon of Riverside; Secretary, John N. Ewer of Oakland.

Pathology and Bacteriology Section—Chairman, Gertrude Moore of Oakland; Secretary, George D. Maner of Los Angeles; Assistant Secretary, Paul H. Guttman of Sacramento.

Pediatrics Section—Chairman, E. Earl Moody of Los Angeles; Secretary, Hartzel H. Ray of San Mateo; Assistant Secretary, W. W. Belford of San Diego.

Radiology Section—Chairman, John D. Lawson, Sacramento; Secretary, Karl M. Bonoff of Los Angeles.

Urology Section—Chairman, Lloyd Kindall of Oakland; Secretary, Carl F. Rusche of Hollywood.

A new feature was developed in the establishing of a scientific exhibit department, which featured forty-two scientific exhibits. The Committee on Awards reached the following appraisals:

First award: "A New Amputation Through the Femur at the Knee"—C. Latimer Callender of San Francisco.

Second award: "Reconstructive Surgery"—Arthur E. Smith and James B. Johnson of Los Angeles.

Third award: "Skin Malignancies"—William H. Sargent of Oakland.

Honorable mention: "Peritoneoscopy"—John C. Rud-dock of Los Angeles.

"Hydronephrosis: Renal Circulation"—Frank Hinman of San Francisco.

"Some Phases of Dentistry Which Are Also of Interest to the Physician"—California State Dental Association.

"New and Simplified Physical Method for Blood Detection"—Frederick Proescher of San Jose, Jesse Carr and A. M. Moody, San Francisco.

It is intended in future years to expand these exhibits and to present visualized demonstration of scientific subjects. Members are now requested to begin the preparation of scientific exhibits for next year's Pasadena session.

ENEMIES

"You have no enemies, you say?

Alas! my friend the boast is poor—

He who has mingled in the fray

Of duty that the brave endure

Must have made foes! If you have none,

Small is the work that you have done;

You've hit no traitor on the hip,

You've dashed no cup from perjured lip,

You've never turned the wrong to right—

You've been a coward in the fight.

"Alas! Poor Yorick."

There is no desire to encourage individuals to go on a drive to make enemies—there is sufficient enmity rampant among men today. The thought in mind is to cause men to pause and ponder, ere shunning another when someone declares that individual to be an enemy. Pause and inquire whether the appellation resulted because a traitor has been exposed, perjury refuted, or attempted wrong was righted. If these or similar causes be the reason, the individual who was branded as an enemy by one whose quest was foiled is not an enemy—he is a person of honor—we wish there were more in business, government, professions, and society.

In the years that have gone, encounters have been had with men listed as enemies of this or that person, persons or organizations. Letters have been seen branding an individual as an enemy, or worse, because the man had exposed and defeated the ulterior quests of the writers of these letters. Men have been discredited because they had the fortitude to stand for that which was right, a principle that was just, and a cause that was fair. In their stand they did tread on the toes of one or more less honorable persons or possibly selfish individuals, and such parties now go about embracing every opportunity and occasion to publicize that "So-and-so is an enemy—beware of him." The warning should be: Beware of *him* who calls another an enemy until you ascertain the justice for such a charge.

Our members, individually and collectively, undergo adverse criticism and discrediting because of the unprofessional conduct and avariciousness of a small minority group. The regrettable part is that the profession is judged and condemned by the acts of these minorities and unprincipled individuals. What is still more serious is that legislators become aware of these unprofessional acts and cite them as being representative of the profession as a whole. It is one of the reasons why desirable legislation is frequently defeated. The acts of one medical man at times brings about widespread adverse criticism in a community of the profession as a whole. A drop of kerosene can spoil a whole crock of butter. An act of a single doctor can react adversely upon the entire profession in a community. Only recently one legislator was extremely bitter, and would have nothing to do with a legislative matter because of the act of a single individual. He stated, "he would have nothing to do with the profession or their legislative quests because of that doctor's professional conduct." Because this doctor was called to account he subsequently embraced every opportunity to condemn and vilify and brand as an enemy the American Medical Association official who sought to prevent recurrence of similar practices.

Professional conduct standards are set forth in our principles of ethics. In these changing times and conditions it behooves every doctor to conform to these principles.

ANNUAL MEETING—BYSTANDER COMMENTS

Fine weather, bright sunshine, beautiful foliage and flowers, golf courses in excellent shape, fine hotels and cuisine—that was, and always is Del Monte.

In the North and South Golf Tournament on Sunday, the North players were the winners.

Excellent attendance at all section meetings. The three general meetings held capacity audiences in earnest attention.

Forty-seven scientific exhibits and forty-two technical exhibits made a splendid showing, and engaged members' attention.

Delegates were alert and attentive to their responsibilities. Discussions were frank and constructive. Resolutions, timely and important. The last session adjourned at 1:10 a. m. with work well done. Reference committees merit generous thanks for their capable discharge of arduous duties.

Fun, fellowship, good cheer and relaxation characterized the President's banquet and ball. There were many sleepy eyes at breakfast on Wednesday morning because of the "wee small hours" of retirement.

Woman's Auxiliary had a fine registration and excellent program. Congratulations to this growing, valuable, efficient organization.

"Fine meeting," "excellent arrangements," "details well executed," "schedules were observed promptly"—these and similar were the many spoken and written expressions.

A few Barber-Shop Quartets held forth on Tuesday night with a marked improvement of voices in minors and sharps.

The opening ceremonies of the House of Delegates, with presentation of gavels to past speakers and certificates to past presidents, was ably conducted in a dignified way by Speaker Roblee. "What do we delegates get?" was asked by a delegate. "Work," was the answer.

Carl Stanley, Nat Head, Mr. Huckins and Mr. Parker of the Hotel Del Monte managerial staff were untiring in their efforts for the comfort and pleasure of the members. There is a rumor that a convention auditorium is to be built in connection with the hotel.

Where is Tom Kelly? was the frequent inquiry. Tom was as sorry as the inquiring members, but professional duties compelled him to remain at home and miss his first meeting in many years.

A fine sight to see the House of Delegates arise en masse to support the nomination of "June" Harris to succeed himself as councilor. "June" surely deserved this tribute.

Hurry along, 1938! Every one is eager for that annual session in Pasadena.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Chairman

The Committee on Public Relations at its Del Monte meeting reflected Charles A. Dukes as its chairman. By constitutional provision Doctor Dukes becomes a member of the Council by virtue of his office.

Proposed Activities

The Committee is developing plans for the coming year and proposes to initiate them early in the fall months.

One activity will be to establish a program of public meetings and lectures, and create a speakers' bureau for these meetings.

Another feature will be the creation of a moving film library for use in local health meetings.

Contacts will be continued with civic organizations and governmental agencies. Whenever possible, invitations will be accepted to address lay organizations on topics and problems of mutual interest and concern.

A Bureau of Public Information will be continued in order to enable lay persons to obtain authoritative answers to their inquiries. During the past year some three hundred such inquiries were answered by mail or telephone and in certain instances by telegraph.

Press releases of health and medical articles will be continued at intervals, and a press bureau contact will be maintained with the three national news agencies, as has been done during the past year.

Other plans and activities will be announced from month to month in this department. Suggestions are invited from all members as to how this department can extend its services.

Medical-Legal Services

The Committee on Unethical and Illegal Practices of the American Bar Association conducted a hearing in Washington on May 2 to determine whether state medical organizations that provided legal defense for members in malpractice suits were practicing corporate law. Corporate law practice has been declared illegal. The inquiry was particularly directed against the Ohio State Medical Association.

On May 8 the following telegram was received:

Am informed that committees on the unauthorized practice of law on professional ethics and grievances of American Bar Association have expressed unanimous opinion that the operation of medical defense plans of one state medical association constitutes unauthorized practice of law. Stop. Presumably this opinion will apply to other state associations. Olin West, Secretary.

The California Medical Association provides no legal defense for its members. Consequently, it is not affected by this decision. Many sister states render such service to members. They are, therefore, confronted with the necessity of discontinuing this service.

To Be a Funeral Director

California laws require that funeral directors and embalmers must be licensed. To be eligible for license the applicant must meet the following qualifications:

- (a) Shall be over twenty-one years of age.
- (b) Shall hold a junior college diploma or shall have completed two years of college.
- (c) He shall have had a full course of instruction in an embalming school of Class A type.

†The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

(d) He shall pass an examination in (1) theory and practice of embalming; (2) anatomy, including histology, embryology, and dissection; (3) pathology, bacteriology; (4) hygiene, including sanitation and public health; (5) chemistry, including toxicology; (6) restorative art, including plastic surgery and demisurgery.

(e) He shall have completed a two-year term of apprenticeship and shall have assisted at the embalming of at least fifty human bodies.

Splendid, excellent! The query is pertinent—why not higher education and training for those licensed cultists who seek to care for the physical needs of the living? Surely, there can be no question as to the necessity of enacting a qualifying certificate law for all who desire to treat the living human being.

Group Hospitalization

For informative purpose the following extract from the American Medical Association Bureau of Economics annual report is presented:

The Bureau of Medical Economics has consistently maintained that the decision as to whether or not a group hospitalization plan is essential must rest primarily with the medical profession and the hospital officials of the local community. Furthermore, if it is decided that a group of hospitalization plan is necessary to complete or to augment the existing hospital facilities of the community, certain principles of organization and administration should be observed. The following principles are suggested in the interest of fairness, efficiency and greater security, and in the event that hospital insurance is deemed necessary:

1. The plan of organization should conform to state statutes and case law. The majority of the governing body of the hospital insurance plan should be chosen from among members of official hospital groups and members of medical societies. Great care should be taken to assure the non-profit character of these new ventures.

2. The plan should include all reputable hospitals. The qualifications of the participating hospitals should be closely supervised. Member hospitals should be limited to those on the hospital register of the American Medical Association or to those approved by the state departments of public health or other state agencies in those states in which there is approval, registration or licensing of hospitals.

3. The medical profession should have a voice in the organization and administration of the plan. Since hospitals were founded to serve as facilitating means to the practice of medicine, the medical profession must concern itself intimately with plans likely to affect the relations of hospitals to physicians.

4. The subscriber's contract should exclude all medical services—contract provisions should be limited exclusively to hospital facilities. If hospital service is limited to include only hospital room accommodations, such as bed, board, operating room, medicines, surgical dressings and general nursing care, the distinction between hospital service and medical service will be clear.

5. The plan should be operated on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs and reserves for contingencies and unanticipated losses. Supervision by state insurance departments has been advantageous for both the buyer and the seller of insurance contracts. Laws permitting the formation of hospital service corporations should not remove the benefits of such supervision nor violate the principles enumerated.

6. There should be an upper income limit for subscribers. If group hospitalization plans are designed to aid persons with limited means to secure hospital services, they should render such service at less than regular rates. If no consideration in rates is made for persons with limited means, group hospitalization plans lose their altruistic purpose and there may be little justification for an income limit.

7. There should be no commercial or high-pressure salesmanship or exorbitant or misleading advertising to secure subscribers. Such tactics are contrary to medical and hospital ethics and are against sound public policy.

8. There should be no diversion of funds to individuals or corporations seeking to secure subscribers for a profit. The moment hospitals lose their traditional character as institutions of charity and humanitarianism the entire voluntary hospital system will break down.

9. Group hospitalization plans should not be utilized primarily or chiefly as means to increase bed occupancy or to liquidate hospital indebtedness. Such plans, if they are necessary, should place emphasis on public welfare and not on hospital finances.

10. Group hospitalization plans should not be considered a panacea for the economic ills of hospitals. They can serve only a small portion of those persons needing hospital services. Hospitals must continue to develop efficient methods of administration and service independent of any insurance method of selling their accommodations.

Notwithstanding the efforts of medical societies and this bureau, as well as the reports of the Judicial Council and the action of the House of Delegates on group hospitalization at the Kansas City session to develop principles for the guidance of the group hospitalization movement, few, if any, of the plans exclude all medical services from their group hospitalization contracts. The extent to which medical services are included in the hospital service contracts is shown in the report of the Bureau.

For many years there have been serious discussions among physicians and hospital administrators concerning the most equitable arrangements for anesthesia, clinical pathology, radiology, and other special medical services in hospitals. These are fields in which hospitals and the medical profession must seek and apply adjustments. Just now, when a more satisfactory relationship in some of these fields seems to be in view, group hospitalization tends to accentuate and perpetuate the very conditions which the medical profession and some hospital authorities have sought to improve. Hospital insurance plans tend to force the continuation of undesirable practices and relations between physicians and hospitals.

These prepayment plans for hospital care show a distinct tendency to place hospitals themselves in the field of medical practice. If group hospitalization organizations become sufficiently strong in membership support, and if they pursue the announced policy of liberalizing benefits, the future course of such plans seems clear. Either they will offer a longer period of hospital stay, or they will include more medical services. It is only occasionally that patients need more than the twenty-one days of hospitalization now offered. At the time of hospitalization every patient needs one or more medical services. Who can deny that the directors of these schemes may propose to include additional medical services to make their contracts more salable? There is only a remote possibility that a future development in these plans will be a decrease in subscription rates.

If group hospitalization schemes were to confine their benefits strictly to hospital facilities, the movement would avoid most of the undesirable disturbances in the field of medical practice without impairing the value of the plan as a method of assisting persons with limited incomes to receive hospital services. In this connection there is need for a thorough understanding on the part of the organizers and administrators of group hospitalization plans as to what constitutes medical services.

Because of the several reasons outlined, group hospitalization, instead of preventing the advent of some form of sickness insurance, is more likely to be the first step toward the opening of hospitals for all persons in the community and then a system of state-managed medicine. The group hospitalization movement is clearly one of the major issues demanding action by the medical profession if the future of medical practice is to be maintained on a basis which guarantees that the welfare of the sick individual is the first consideration.

COMPONENT COUNTY MEDICAL SOCIETIES

MARIN COUNTY

The regular meeting of the Marin County Medical Society was held Thursday evening, April 22, at the Marin Golf and Country Club.

Dr. J. B. McNaught of Stanford University gave an interesting talk on *Trichinosis*.

CARL W. CLARK, *Secretary*.

✽

PLACER COUNTY

The Placer County Medical Society met on April 17 at the Freeman Hotel, with President C. Ettrick Lewis presiding. The meeting was called to order at 8:15 p. m. In addition to President Lewis, there were present the following members and visitors:

Members—Doctors Schofield, Hirsch, Eveleth, Peers, Miller, March, Atkinson, Empey, Rood, Hummelt, Lundegaard, Dunievitz, Briner, L. B. Barnes, Padgett, Kindopp, and Mackay.

Visitors—Dr. F. Lynn Smith of Colfax, Dr. C. E. Schoff of Sacramento, Councilor for the Eighth District of the

California Medical Association; and Mr. Ben H. Read, Executive Secretary, Public Health League of California.

The minutes of the meeting of January 9 were read and approved.

Dr. F. Lynn Smith's application for transfer of membership from the Tulare County Medical Society to the Placer County Medical Society was acted upon favorably.

Dr. Emmeline Banks of Auburn was elected to membership in the Placer County Medical Society.

Correspondence received by the secretary since the last meeting was read and ordered filed.

The president, Doctor Lewis, reported an autopsy on a man accidentally killed which showed an advanced stage of silicosis although, during his lifetime, the patient had exhibited no symptoms of silicosis and suffered no disability. Doctor Dunievitz, in discussing the case, made the following suggestions:

1. That any member having an interesting case for autopsy invite his medical confrères to be present.

2. The advantage of using autopsy material at the county hospital.

3. The appointment of a committee to bring in recommendations regarding the above suggestions.

Dr. Richard O. Schofield of Sacramento, a member of our society and a former president of the Nevada State Medical Association, gave a most interesting and instructive address upon *The Management of the More Common Types of Fractures*. Doctor Schofield discussed the subject from the standpoint of what the man in general practice might meet with in his routine daily work, not as the specialized treatment, but as the recognition, the pathology, and some of the adjuncts of treatment that help to produce better end-results and also which give the patient comfort and relief of pain during the course of treatment. It was suggested that the use of the aeroplane splint for the so-called shoulder sprains always made for a lessened amount of discomfort, which very often is caused by the simple weight of the arm hanging by the side; the ease with which novocain injected directly into the site of the fracture was stressed as being of very decided help to the man who is practicing alone and cannot call upon professional help without a great deal of inconvenience. Firm strapping, which included the whole hand and one-half of the forearm, will give relief in wrist sprains, where the ordinary application of one or two strips of one-inch adhesive is of very little value at any time; the use of metal splints for injuries which occur to the hands or the fingers and often-times returns a man to his usual work days, and sometimes weeks, before the wound or the bone has entirely healed. Actual fractures of the olecranon and patella are probably always best treated by open reduction; it may be accomplished by the apposition of the fragments with sutures through drilled portions of the bone, or may be accomplished by circumferential capsular sutures. Injuries involving the knee can be made more comfortable in the ambulatory stage by the use of the built-up heel or sole on the inner or outer surface, as the case may be, for the particular injury involved. The use of the metatarsal bar on the shoe was considered in regard to fractures of the large toe and also of the metatarsals. The mechanism of the production of fractures and the treatment of specific fractures of the limbs were discussed in some detail, the same being made clear by their demonstration on the actual skeletal manikin. Discussion was by Doctors Rood, Empey, Atkinson, Kindopp, Mackay, Briner, Lewis, Peers, and Schofield.

Dr. C. E. Schoff, Councilor for the Eighth District, gave a short report of legislative matters and the work of the Council. He also called attention to the desirability of attending the California Medical Association meeting at Del Monte.

President Lewis called upon Mr. Ben H. Read, Executive Secretary of the Public Health League of California. This being Mr. Read's first visit to the Placer County Medical Society, he gave our members a description of the make-up of the Legislature, of its powers and of its *modus operandi*. He then discussed very fully the more important of the bills before the present Legislature dealing with the profession of medicine and the public health. Considerable discussion followed the address.

Meeting adjourned for refreshments.

ROBERT A. PEERS, *Secretary*.

SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Raymond Wallerius, on April 20 at the Auditorium on Twenty-ninth and L streets. There were fifty-six members and guests present.

The speaker of the evening, Dr. A. H. Rowe of Oakland, gave an excellent talk on the *Problems in Clinical Allergy*. Of two thousand students examined at the University of California, 35 per cent gave a family history of allergy, and 33 per cent a personal history of allergy. Doctor Rowe stated that 10 per cent of all people have allergic manifestations that need trained medical care. The theories of allergy, as well as the diagnosis, specific causes, and treatment, were discussed in detail. The talk was illustrated with lantern slides. The subject was then discussed by Doctors Bramhall, Soutar, Vance, and Turner.

The applications for membership of Doctors Milton Sarkisian, William Harding, and Wilfred Lowe were read for the first time. The application of Dr. E. R. Cole for transfer into the Society was read for the second time, and he was unanimously elected to membership. The application of Dr. Adrian Crossen for transfer into the Society from Placer County was read for the first time.

Dr. Paul Guttman was elected an alternate delegate to the convention at Del Monte.

Dr. F. MacDonald made a resolution that the Society go on record as approving a resolution for the elimination of taxes for nonprofit hospitalization insurance. Resolution passed.

Doctor Soutar made a motion that the Society go on record as disapproving Assembly Bill 1880 (Clark), which would enable osteopaths to obtain public health certificates. Resolution passed.

G. E. MILLAR, *Secretary*.

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SAN DIEGO COUNTY

San Diego was well represented during the convention at Del Monte. We wish to congratulate our member, Dr. George Huff, on the presentation of his paper.

Dr. L. C. Kinney was reelected to the position of delegate to the American Medical Association.

Locally, many lectures of interest have held our attention. Dr. C. H. Best of Toronto discussed the following before the Academy of Medicine: (1) *Prolongation of Insulin Action*. (2) *Thrombosis From the Experimental Viewpoint*.

Dr. Elmer Belt of Los Angeles read a paper regarding *Hyperpyrexia in the Treatment of Nisserian Infections*. This at the dinner meeting of the San Diego County Medical Society.

The San Diego Galen Club will consider the complications of female pelvic disease at its next dinner meeting.

F. E. TOOMEY, *Chairman, Publicity Committee*.

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SANTA BARBARA COUNTY

The regular meeting of the Santa Barbara County Medical Society was held Monday evening, April 12, at the Bissell Auditorium of the Cottage Hospital.

Dr. William H. Goeckerman of Los Angeles, member of the State Syphilis Committee, spoke concerning the *New Syphilis Movement and the General Practitioner*.

The meeting was well attended by members of the profession and others interested in the subject. The speaker explained what the United States Public Health Service wished to accomplish in the eradication of this disease, and how the profession and interested organizations could aid.

The paper was discussed by Doctors Wilson, Ussher, Roome, Stevens, and Burtness.

At the conclusion of the discussion the Society went into executive session.

The names of Dr. Peter Cohen and Dr. Yukio Miyauchi, both of Santa Maria, and Dr. Richard Hipp of Santa Barbara were proposed and, after balloting, were declared elected into membership of the Society.

Doctor Ullmann gave a report of the activities of the State Council.

A motion was made, seconded and carried, that the May meeting of the Society be held in Santa Maria, under the auspices of the Santa Maria branch.

WILLIAM H. EATON, *Secretary*.

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SAN BERNARDINO COUNTY

The regular meeting of the San Bernardino County Medical Society, held at the San Bernardino County Charity Hospital on Tuesday, May 11, was called to order by the president, Doctor Mock, at 8:15 p. m., with fifty members and guests present.

It was moved and seconded that the Medical Advisory Committee to the S. R. A. be dismissed, since the necessity for this committee no longer exists, and that the Society extend a vote of gratitude to this committee for their time and splendid work in forming the first S. R. A. medical program in the State and making it a success. Passed.

Dr. C. N. Abbott of Ontario announced the opening of their new clinic building, and extended an invitation to all members to attend the "open house" and inspect the building and equipment.

The following applications for membership were approved: Dr. Christopher W. Hartsough, Jr., of Patton and Dr. Christopher A. Mason of Loma Linda.

A telegram from Doctor Warnhuis, regarding bills before the Legislature, was read. Members were urged to send telegrams to senators and assemblymen urging them to defeat these measures.

A letter from Doctor Dickie, State Health Officer, regarding the appointment of a successor to Doctor Godfrey, was read.

Dr. Harold Gentry, delegate to the California Medical Association, reported on the meeting of the House of Delegates held at Del Monte, May 2 to 6. California Medical Association dues for next year will be \$10.

The program of the evening was given by members of the Cancer Clinic, as follows:

Radiology in Cancer, with Particular Reference to Cancer of the Breast and of the Skin—Dr. Frank Folkins of Redlands.

The Incidence of Cancer—Dr. Harold Gentry of Redlands.

Work of the Cancer Committee at the San Bernardino County Charity Hospital for the Year 1936—Dr. Carlos G. Hilliard, Chairman of Cancer Committee.

Pathology of Structure and Pathways of Dissemination in Cancer of the Breast and of Skin—Dr. Oran I. Cutler of Loma Linda.

The subject was then discussed by Doctors Thureson of Riverside, C. N. Abbott, A. D. Butterfield, with Doctor Hilliard closing by extending a cordial invitation to all members of the Society to attend the Cancer Clinic, and to bring such patients as they would like to present for consultation.

The meeting adjourned at 10:30 o'clock, following which refreshments were served.

ARTHUR E. VARDEN, *Secretary*.

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SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held on May 6.

The meeting was called to order by Doctor Boehmer. The minutes of the previous meeting and of the Board of Directors were read and accepted.

The papers of the evening were presented by Dr. Philip J. Lipsett of Oakland, who spoke on *Amputations—Indications for—Circulatory and Skin Tests—Prosthesis*, and Dr. Frank McCullough, also of Oakland, who talked on the *Injection Treatment of Herniae*.

There was an interesting exhibit of artificial arms and legs by Mr. C. H. Hittenberger.

There being no further business the meeting was declared adjourned and refreshments were served.

G. H. ROHRBACHER, *Secretary*.



TULARE COUNTY

The Tulare County Medical Society met in regular session on Sunday, April 25, at 6:30 p. m. The meeting was held at Motley's Café in Visalia, and was preceded by dinner. President Hill called the meeting to order.

Doctor Zumwalt introduced the speaker of the evening, Dr. A. E. Belt, urologist of Los Angeles. His subject was *Gonorrhea—Its Mode of Transmission, Invasion, and Treatment*. He described the newer fever therapy by means of a "hot-air cabinet," and reports a cure in 96 per cent of cases in a present series of about one hundred cases. The patient is kept in the hot-air cabinet for ten hours at a temperature of 106.79. The discourse was well illustrated with lantern slides, and later evoked a lively discussion. Doctor Belt was given a vote of appreciation for his excellent paper.

Communications were read informing of the transfer of Dr. L. Smith to the Placer County Medical Society. Dr. L. Leidig has applied for transfer to the Los Angeles district.

Doctor Zumwalt revived the issue of a full-time health officer in Tulare County, and Doctor Betts made a motion that the president appoint a committee of three to consider ways and means of securing a full-time health officer in this county. The motion was seconded by Doctor Tourtellott and unanimously carried.

Doctor Hill reported on the recent request of the Tulare County Board of Supervisors to meet with them. Doctors Hill and Weiss met with the Supervisors and were asked by Alfred Elliott, Chairman, for cooperation in medical matters pertaining to the County Hospital. The Society expressed unanimous approval of this and instructed the secretary to notify Mr. Elliott of our willingness to cooperate.

The death of Doctor Beck was announced and the meeting adjourned in his memory. KARL F. WEISS, *Secretary*.

CHANGES IN MEMBERSHIP

New Members (38)

Alameda County.—James Hilgesen, Carson E. Hunt, Marshall B. Tucker, R. James Walker.

Lassen-Plumas County.—Herman G. Levin.

Los Angeles County.—Otto Arndal, Willis A. Bird, Robert M. Francis, Elmer W. Gilbert, G. Stanley Gordon, O. Dale Lloyd, B. F. Miller, James G. Rea, Walter C. Rogers, Ewing L. Turner, Roy M. Van Wart, W. Earl Wallace, Sheldon K. Wirt.

Mendocino-Lake County.—George S. Wrinkle.

Monterey County.—A. E. Ghillotti, C. F. Schilling.

Riverside County.—William H. Blackman.

San Bernardino County.—Victor O. Ross, Walter A. Sullivan, Roger A. Vargas.

San Diego County.—Harold C. Torbert.

San Francisco County.—Albert G. Clark, Alvin J. Cox, Jr., Bessie Yeen Jeong.

San Mateo County.—Allan H. Williams.

Santa Barbara County.—Peter Cohen, Yukio Miyauchi, Richard Hipp.

Santa Clara County.—Milo Ellik, W. H. Gardenier, D. L. Morse, Erman Stadler.

Siskiyou County.—J. B. McGuire.

Transferred (1)

Thomas W. Hagerty, from San Joaquin County to Ventura County.

Resigned (1)

M. M. Hare, from Los Angeles County.

In Memoriam

Ellis, James Alexander. Died at Alameda, May 1, 1937, age 59. Graduate of the University of California Medical School, San Francisco, 1903. Licensed in California in 1904. Doctor Ellis was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



Mountford, George Thomas. Died at Coalinga, May 2, 1937, age 52. Graduate of the Northwestern University Medical School, Chicago, 1909. Licensed in California in 1910. Doctor Mountford was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



Trowbridge, Dwight Howe. Died at Fresno, May 4, 1937, age 67. Graduate of Tulane University of Louisiana School of Medicine, New Orleans, 1893, and licensed in California the same year. Doctor Trowbridge was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



Wade, Lyman Trevitt. Died at San Luis Obispo, April 11, 1937, age 70. Graduate of Bennett College of Eclectic Medicine and Surgery, Chicago, 1888. Licensed in California in 1894. Doctor Wade was a member of the San Luis Obispo County Medical Society, the California Medical Association, and the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

Officers for Coming Year

President—Mrs. Hobart Rogers, 1137 Mandana Boulevard, Oakland.

President-Elect—Mrs. John V. Barrow, 142 South Windsor Boulevard, Los Angeles.

First Vice-President—Mrs. Frederick Scatena, 1400 Forty-first Street, Sacramento.

Second Vice-President—Mrs. Elliott G. Colby, 2457 Willow Street, San Diego.

Recording Secretary—Mrs. Harry E. Henderson, 1600 Orange Road, Santa Barbara.

Corresponding Secretary—Mrs. Charles C. Hall, 207 Estates Drive, Piedmont.

Treasurer—Mrs. Harry O. Hund, 400 Grand Avenue, San Rafael.

Councilors-at-Large:

Mrs. W. W. Roblee, 3117 Orange Avenue, Riverside.

Mrs. Fred H. Zumwalt, 3880 Clay Street, San Francisco.

Mrs. A. E. Anderson, 1035 Cambridge Avenue, Fresno.

Mrs. Arthur T. Newcomb, 1 Richland Place, Pasadena.

District Councilors:

First District—Mrs. Dexter Ball, Santa Ana.

Second District—Mrs. Benjamin H. Sherman, 1622 Fairfax, Hollywood.

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Fred Zumwalt, Chairman of the Publicity and Publications Committee, 3880 Clay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Zumwalt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue for Woman's Auxiliary notes.

Third District—Mrs. E. L. Markthaler, 2304 State Street, Santa Barbara.

Fourth District—Mrs. George Walker, 630 Peralta Way, Fresno.

Fifth District—Mrs. Lawrence Knox, Carmel-by-the-Sea.

Sixth District—Mrs. J. C. Geiger, 50 Ventura Avenue, San Francisco.

Seventh District—Mrs. Harold Trimble, 26 Pacific Avenue, Piedmont.

Eighth District—Mrs. George A. Briggs, 1127 Forty-fifth Street, Sacramento.

Ninth District—Mrs. Robert M. Furlong, Linden Lane, San Rafael.

Parliamentarian—Mrs. William H. Sargent, 109 Beechwood Drive, Oakland.

Resolutions Adopted at Del Monte Session

During the recent session of the Woman's Auxiliary to the California Medical Association the following resolutions were passed:

WHEREAS, The 1937 annual session of the Woman's Auxiliary to the California Medical Association held at Del Monte is about to become another milestone in the history of its progress; and

WHEREAS, Many persons and agencies, in addition to a magnificent setting, have contributed to this highly enjoyable meeting; therefore be it

Resolved, That the Woman's Auxiliary to the California Medical Association, in convention assembled, extend its sincere thanks and grateful appreciation:

To Mrs. John Hunt Shephard and her committee for their difficult work and careful attention that have done so much for the success of the session and pleasure of the members and their guests.

To Mrs. H. M. Yates, chairman of the musicale, who with her selected group of artists—Mrs. Gladys Steele, Mrs. Mary Rosalie Haslett, Mr. Charles Frisbee, and Dr. Lawrence M. Knox—contributed to the success of the very delightful evening of music.

To the management and staff of the Hotel Del Monte and Del Monte Lodge for their courtesies.

To Rev. Stewart C. Potter of Monterey, who asked God's blessings on our sessions.

To the Council of the California Medical Association for their support and cooperation throughout the year.

To Dr. William J. Kerr and members of the Advisory Council of the California Medical Association for their cooperation and support and their sympathetic understanding of our problems as an auxiliary.

To Dr. John V. Barrow, Dr. Edward M. Palette, and Dr. George D. Huff for inspiring messages.

To Dr. George H. Kress and Dr. Frederick C. Warnshuis for additional space and courtesies in the publication of Auxiliary news in CALIFORNIA AND WESTERN MEDICINE.

To the Monterey press for its cooperation and able presentation of material pertaining to our annual meeting.

To Mrs. Robert E. Fitzgerald, our National president, for her cheerful and gracious greetings and her words of encouragement and counsel.

To Mrs. Andrew J. Thornton, our State president, whose administrative genius we have much admired, and because of her real leadership and gracious manner which has endeared her to every member of the organization and to the other members of our State Board who have so ably carried their duties to a successful completion.

Be it further

Resolved, That copies of these resolutions be sent by the recording secretary of the convention to the above-named, to whom we are so deeply indebted, and a copy to be placed on file.

MRS. CHARLES C. HALL, *Recording Secretary*.

News Letter

Dear Auxiliary Members:

The convention at Del Monte was very successful, and nearly three hundred members were registered. These ladies attended one session at least, and most of them remained for all sessions and entertainment.

Much credit and a great deal of praise and thanks go to Mrs. Shephard and her committee for their splendid work. It was a difficult task for Mrs. Shephard when one realizes that she lives about seventy miles from Del Monte, and also that she was in ill health and really should not have had any worries at all. The Monterey Auxiliary was a tower of strength to her, and helped in every possible way to make the convention a success. Congratulations to you all on the splendid programs you arranged for our entertainment. I think the concert in honor of Mrs. Palette was especially delightful, but I must not praise it more than the luncheon given in honor of Mrs. Thornton (at which time San Diego received the coveted Doane Membership Cup), nor the beautiful tea in honor of Mrs. Fitzgerald, our National president, and Mrs. Hobart Rogers, our new State president. It would be hard to say which event was the nicest, so we thank you for all of them.

The convention report will be published in next month's CALIFORNIA AND WESTERN MEDICINE.

And now a few words to you before I close this article. Our new editor and chairman of publicity is Mrs. Fred Zumwalt, 3880 Clay Street, San Francisco. Please make her work as easy as possible by sending all communications to her promptly, so she can edit them and send them to CALIFORNIA AND WESTERN MEDICINE on time. She will appreciate it and will enjoy her work so much more if she can depend on you as I have done.

I thank you for your cooperation this past year; it made it easy for me to do my part.

Yours most sincerely,

MRS. ROBERT M. FURLONG.

Seen and Heard at Del Monte

Mrs. Kelly Canelo, our hard-working secretary of last year, sitting with the delegates and really enjoying the convention this year.

Mrs. Frank Makinson, smiling and carefree after turning over a careful of books and papers to a worried-looking Mrs. Hund.

Sincere regret that Mrs. Thomas Clark was too ill to be present at any of the sessions and unable to preside at the luncheon in honor of Mrs. Thornton, but gratitude to Mrs. Philip Schuyler Doane for gallantly saving the day and making the luncheon a great success.

How charming our hostesses looked at the tea in Mrs. Rogers' honor.

Much pleasure that Mrs. Robert Fitzgerald, our National president, was present at the first session of the convention, the first time such an honor has been conferred in California at convention time.

Mrs. John Hunt Shephard looked her usual charming self and disguised, under a gracious smile of welcome, the pain she was suffering.

And the many compliments that were heard on all sides for the smoothness with which everything was arranged for our comfort. Santa Clara and Monterey (our youngest auxiliary) have proved they know how to do things right.

Component County Auxiliaries

Alameda County

The Woman's Auxiliary to the Alameda County Medical Association met at the Claremont Country Club on April 16 for their luncheon and meeting. The clubroom was beautifully decorated with blue and white iris of the season. There were eighty-three members and guests present. The president, Mrs. Page, introduced Mrs. Hobart Rogers as president-elect of the Woman's Auxiliary to the California State Medical Association for 1937-1938.

Mrs. Rogers, Chairman of the Nominating Committee, composed of Mesdames Rogers, John Ewer, D. E. Jeffry, Walter C. Adams, and Charles E. Peters, made the following report: Mrs. Frank S. Baxter, president-elect; Mrs. George Calvin, vice-president; Mrs. Richard Young, corresponding secretary; Mrs. Maxwell Thebaut, recording secretary; and Mrs. Robert Cutter, treasurer. For the board of directors, Mrs. Grant Ellis, Mrs. John C. Condit and Mrs. Harry Akesson.

Mrs. Baxter announced that the May meeting would be the annual one for Mother's Day. Mrs. Page asked for a volunteer committee to assist in the arrangements. Twelve members responded, and Mrs. W. H. Sargent was appointed chairman.

Mrs. Alexander, Chairman of the Membership Committee, reported that the membership, as of May 15, 1936, was 199. The paid-up membership now totals 244. The increase of forty-five members has been due to the efforts of the Membership Committee and with the coöperation of the entire Auxiliary. The following new members were announced: Mesdames John Daugherty, James Campbell, A. L. Guerra, David Hadden, and Melvin A. Shade.

Mrs. Baxter introduced Mr. E. W. Jacobsen, Superintendent of the Oakland Public Schools, who delighted us with a talk on *Pagants of Europe*. His talk was illustrated with beautifully colored lantern slides, and was greatly enjoyed by all who heard him.

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Los Angeles County

The regular meeting of the Woman's Auxiliary to the Los Angeles County Medical Association was held on Tuesday, April 27, at the Valley Hunt Club in Pasadena with about 170 members present.

The dining room was abloom with Pasadena's choicest flowers, and a charming garden scene with a Maypole and singing birds was arranged on the stage, giving a delightful spring setting.

Dr. Alvin G. Foord, director of laboratories at the Huntington Memorial Hospital, spoke briefly on the work and future plans of that institution, and then introduced the next speaker, Mr. Lindley Bynum, field representative of the Huntington Library. Mr. Bynum gave a very interesting talk on the *Huntington Library and Art Gallery and Its Collections*, discussing briefly the various departments and their functions.

The regular business of the meeting was conducted quickly by Mrs. Clifford Wright, President, who presided, so as to permit the members to spend the rest of the afternoon at the Huntington Library.

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Marin County

A bridge tea was given by the Woman's Auxiliary to the Marin County Medical Society on Friday afternoon, April 23, at the Improvement Club in San Rafael. Thirty-two tables of bridge were in progress during the afternoon. At four o'clock, tea was served. A beautiful azalea plant was awarded as door prize. Proceeds from the tea swell the coffers of the Auxiliary by \$52. Mrs. Robert M. Furlong was in charge of the affair.

Dr. Fred H. Kruse of San Francisco addressed the Auxiliary on Thursday evening, April 22, at the Marin Golf and Country Club on *What Women Should Do After Forty*.

Several of our members are looking forward to attending the convention at Del Monte in May.

BERDELLA M. ROBERTSON, *Publicity Chairman*.

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San Diego County

The Woman's Auxiliary to the San Diego County Medical Society have had a busy program these past three months.

On February 9, five benefit bridge teas were held in the homes of Mrs. F. G. Lindemulder, Mrs. Alex Lessen, Mrs. Elliott Colby, Mrs. R. H. Sunderburg, and Mrs. R. E. Bond. Proceeds of these parties were added to our benevolent fund.

On February 24 a health education program, under the leadership of Mrs. E. H. Christopherson, Chairman of Public Relations Committee, was presented at the Young Men's Christian Association. Four prominent San Diego physicians spoke on *What's New in Medicine*. Approximately 150 lay persons were present at this meeting.

On March 8, at our regular monthly luncheon, Mrs. James F. Percy, Chairman of the National Revisions Com-

mittee, talked on the *Aims and Problems of the National Auxiliary*. At this meeting, the president, Mrs. F. G. Lindemulder, announced that \$10 had been given to the building fund of the Society for Crippled Children, \$25 had been given the San Diego Visiting Nurses' Association for five memberships in the organization, and \$50 had been sent to the newly established Auxiliary's lending library.

Dr. C. O. Tanner was guest speaker at the luncheon meeting on April 13. His topic was *Present Trend in Socialized Medicine*.

It was with great pride that the treasurer reported that all 160 members had paid their annual dues. There are 155 active members and five associate members.

ELIZABETH R. BELFORD, *Secretary*.

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Santa Barbara County

In April Santa Barbara had a luncheon meeting at the home of Mrs. Edward J. Lamb for the purpose of electing officers and making plans for the annual benefit bridge tea. Those elected were: Mrs. H. E. Henderson, president; Mrs. Richard McGovney, vice-president; Mrs. P. A. Gray, recording secretary; Mrs. Verril Findlay, corresponding secretary; Mrs. C. F. Nicholas, treasurer.

The Auxiliary maintained a table downtown one day of Cancer Control Week, at which \$50 was taken in for the use of the Cancer Control Commission.

In the campaign against the measure of opening the county hospitals to pay-patients, the Auxiliary took an active part. We obtained twenty-six signatures of lay persons for a telegram which we sent to our Senator Hollister, a member of the Committee on Constitutional Amendments.

At the April meeting, Dr. Irving Wills, President of the County Medical Society, reported on his trip to Sacramento and on the encouraging aspects of that visit made in company with Dr. P. A. Gray, Past President. The bill, while not killed in committee, after a hot debate was sent to the Senate with the recommendation, "Do not pass."

The annual bridge tea was a very successful affair, attended by about 160 of the wives of doctors and dentists and their friends. It was held on the afternoon of April 23 at La Cumbre Country Club. A beautiful spring day made it possible to enjoy tea on the terrace, where the rolling hills of the golf course, dotted with live oaks, led away to the distant vista of the sea and Channel Islands. Several young daughters of the doctors made a charming picture in their semi-formal dresses, their hair flower-decked, as they sold candy and passed sandwiches and cake. Much credit goes to Mrs. William R. Hunt, President, and to her hard-working committee, for the very evident success of the party. Sixty-five dollars was raised.

MRS. H. E. HENDERSON, *Publicity Chairman*.

Infected Tonsils and Rheumatism in Children.—Aitken declares that there is much evidence in support of the theory that an acute infection of the nasopharynx by hemolytic streptococcus has a definite relationship to attacks of acute rheumatism, and some evidence to support the opinion that chronically infected tonsils have an injurious effect on the rheumatic child in the sense that, although their removal may not prevent the onset of the disease, it does minimize the chance of serious cardiac complications and recurrences. A preliminary tonsillectomy, or one performed early during the course of the infection, may possibly, in the case of arthritis, render the heart less liable to be attacked, but not so in the case of chorea. Tonsillectomy in the case of carditis following arthritis seems to have a beneficial effect on the progress of the disease, but not in carditis following chorea. The analysis of 117 cases seems to show that the progress in those cases which did not require tonsillectomy and those in which tonsillectomy was done before the onset of juvenile rheumatism was rather more satisfactory than in those in which tonsillectomy was required at the onset of juvenile rheumatism. The patients who had not been tonsillectomized but who did not require tonsillectomy had the most satisfactory result, but those who had had complete tonsillectomy before the onset of the disease had nearly as good results.—*Medical Press and Circular (London)*.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 7-11. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Hotel Huntington, Pasadena (date to be announced later), 1938. F. C. Warnshuis, M. D., 450 Sutter Street, San Francisco, Secretary.

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Pacific Northwest Medical Association, Great Falls, Montana, July 8-10. C. W. Countryman, M. D., 407 Riverside Avenue, Spokane, Washington, Secretary.

Vancouver Medical Association Summer School, Vancouver, B. C., June 22-25. J. R. Naden, M. D., 203 Medical-Dental Building, Vancouver, Secretary.

Medical Broadcasts*

San Francisco County Medical Society

A radio broadcast program for the San Francisco County Medical Society for the month of June is as follows:

Tuesday, June 1—KYA, 6 p. m.
Tuesday, June 8—KYA, 6 p. m.
Tuesday, June 15—KYA, 6 p. m.
Tuesday, June 22—KYA, 6 p. m.
Tuesday, June 29—KYA, 6 p. m.

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Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of June is as follows:

Thursday, June 3—KECA, 10:45 a. m., The Road to Health.
Saturday, June 5—KFI, 9:15 a. m., The Road to Health; KFAC, 10:15 a. m., Your Doctor and You.
Thursday, June 10—KECA, 10:45 a. m., The Road to Health.
Saturday, June 12—KFI, 9:15 a. m., The Road to Health; KFAC, 10:15 a. m., Your Doctor and You.
Thursday, June 17—KECA, 10:45 a. m., The Road to Health.
Saturday, June 19—KFI, 9:15 a. m., The Road to Health; KFAC, 10:15 a. m., Your Doctor and You.
Thursday, June 24—KECA, 10:45 a. m., The Road to Health.
Saturday, June 26—KFI, 9:15 a. m., The Road to Health; KFAC, 10:15 a. m., Your Doctor and You.

University of California Catalogue of Pictures of Medical Men.—Under the direction of the State Medical Library, there has been arranged in the Crummer Room for Medical History of the University of California Medical School, San Francisco, a special catalogue of pictures of medical men. This catalogue was made by Mrs. Francis Tomlinson Gardner, Assistant Librarian of the State Medical Library. It includes some twenty thousand items, and lists the sources where the pictures may be found. This unique catalog is available for the use of California physicians. Inquiries may be addressed to Mrs. Gardner. If a picture of the person desired is available, a photographic reproduction will be furnished at a nominal charge to those desiring it.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject, to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Golden Gate Bridge Facts.—The Golden Gate Bridge Fiesta Citizens' Committee gives the following Golden Gate Bridge facts:

Length over all	9,200 feet
Length of main spans (longest in the world by 700 feet)	4,200 feet
Length of side spans	1,125 feet
Cost	\$35,000,000
Decks	One
Width of roadway (six auto lanes)	60 feet
Sidewalks (each 10½ feet wide)	Two
Clearance over high water (span center)	220 feet
Height of deck above water (at center)	266 feet
Height of two bridge towers (highest in the world) ..	746 feet
Annual automobile capacity	70,000,000
Annual truck and bus capacity	6,000,000
Length of arch span (Fort Point) ..	319 feet
Height of arch span (Fort Point)	200 feet

Class Reunion and Dinner: Cooper, 1905.—During the session of the California Medical Association the class of 1905, Cooper Medical College, had a reunion and dinner. Those attending indulged in the usual reminiscence: "Do you remember—?" and "What has become of—?" The class roll was called and the following were present: Dr. Archibald A. Atkinson, Dr. and Mrs. Irving J. Beattie, Dr. and Mrs. Adolph Berg, Dr. and Mrs. Percival Dolman, Dr. Reuben H. Hunt, Dr. and Mrs. P. N. Jacobson, Dr. Edwin Merrithew and his son, Doctor Merrithew, Dr. Roy H. Morris, Dr. and Mrs. William Quinn, Dr. and Mrs. William James Quinn, Dr. and Mrs. Calvin Walker. Dr. and Mrs. Harry R. Oliver were honor guests of the group representing the Cooper Medical College faculty.

A very pleasant evening was enjoyed by those who were able to attend. Those present at this happy event pledged that they would make every effort to be present at a meeting projected for 1939, D. v.

Medical School Given Mementos of Amazing Operation.—The extensive medical library of the late Dr. Charles Brooks Bingham, the only practitioner known to have removed a human stomach without having the patient succumb in a short period of time, has been presented to the University of California Medical School and is now installed in the Crummer Room of the school. A unique part of the exhibit is the actual stomach which Doctor Bingham removed, together with a description of the operation, which is still regarded as an amazing bit of medical procedure.

Doctor Bingham, who was a member of the Medical School faculty for a number of years, performed the operation on a San Francisco woman in St. Luke's Hospital here in 1898. Dr. Langley Porter, present dean of the school, administered the anesthetic. The operation was performed in a desperate effort to save the woman's life, and so well was it done that she lived in apparently good health for seventeen more years, the only time in medical history that such a long sustained recovery from this type of operation has been recorded.

Doctor Bingham, who was born in 1849, and died in 1903, was also an authority on diabetes, having done much to relieve sufferers from that disease long before the discovery of insulin. His writings on the subject of diabetes are still referred to frequently by members of the medical profession. The library as a whole is a fairly complete history of the progress of medicine in the last three-quarters of the nineteenth century.

The Medical School has made a request to the doctors of the State to send all available old-time books, pamphlets, medical instruments and other exhibits to the school, if they so desire. They will be placed in the Crummer Room with all due acknowledgment to the donors.

Western Branch of the American Urological Association.—The annual convention of the Western Branch of the American Urological Association will be held at Mt. Rainier National Park, July 12, 13, and 14. For further information, address the secretary, Dr. J. C. Negley, 105 Professional Building, Glendale, California.

American Board of Surgery Organized.—In answer to the widespread demand for an agency which will attempt to certify competent surgeons, the American Board of Surgery has recently been organized. This Board is a member of the Advisory Board of Medical Specialties, which includes all of the boards of certification for the different medical specialties which have been already organized. Since boards were in existence for the certification of practitioners of some of the surgical specialties, such as ophthalmology, otolaryngology, obstetrics and gynecology, genito-urinary surgery and orthopedic surgery, it is expected that the American Board of Surgery will be responsible for the certification of general surgeons as well as those practicing in the remaining specialized subdivisions of surgery.

Acting upon the invitation of the American Surgical Association, the following surgical societies cooperated in the creation of the American Board of Surgery: the American Surgical Association, the Surgical Section of the American Medical Association, the American College of Surgeons, the Southern Surgical Association, the Western Surgical Association, the Pacific Coast Surgical Association, and the New England Surgical Society. The first three of these bodies which are national in scope have three representatives on the board. All of the other societies have one representative each. The representatives of the cooperating societies are nominated by the society which they represent and upon approval of the Board shall become members of it. The term of membership on the board will be six years. The following were chosen to represent the cooperating surgical societies:

Representing the American Surgical Association—Drs. Evarts A. Graham, Arthur W. Elting, and Allen O. Whipple.

Representing the American College of Surgeons—Drs. Donald Guthrie, Erwin R. Schmidt, and Harvey B. Stone.

Representing the Surgical Section of the American Medical Association—Drs. Fred W. Rankin, Howard M. Clute, and J. Stewart Rodman.

Representing the New England Surgical Society—Dr. Philemon E. Truetsdale.

Representing the Western Surgical Association—Dr. Thomas Orr.

Representing the Southern Surgical Association—Dr. Robert Payne.

Representing the Pacific Coast Surgical Association—Dr. Thomas Joyce.

The following officers were elected: Dr. Evarts A. Graham, chairman; Dr. Allen O. Whipple, vice-chairman; Dr. J. Stewart Rodman, secretary-treasurer.

Two groups of candidates are recognized for qualification by the Board.

(a) Those who have already amply demonstrated their fitness as trained specialists in surgery.

(b) Those who, having met the general and special requirements exacted by the Board, successfully pass its qualifying examination.

The first of these groups, the Founders' Group, upon invitation by the Board will be chosen from the following:

1. Professors and associate professors of surgery in approved medical schools in the United States and Canada.

2. Those who for fifteen years prior to the Board's organization have limited their practice to surgery.

3. Members of the American Surgical Association, the Southern Surgical Association, the Western Surgical Association, the Pacific Coast Surgical Association, and the New England Surgical Society, who were in good standing January 9, 1937.

All applications for the Founders' Group must be received within two years of the Board's organization, January 9, 1937. No candidates for the Founders' Group will be considered after that date.

Requirements for those to be qualified by examination will be as follows:

1. Graduation from a medical school of the United States or Canada recognized by the Council on Medical Education and Hospitals of the American Medical Association or graduation from an approved foreign school.

2. Completion of an internship of not less than one year in a hospital approved by the same Council, or its equivalent in the opinion of the Board.

3. *Special Training.*—A further period of graduate work of not less than three years devoted to surgery taken in a recognized graduate school of medicine or in a hospital or under the sponsorship accredited by the American Board of Surgery for the training of surgeons. This period of special training shall be of such character that the relation of the basic sciences of anatomy, physiology, pathology, bacteriology, and biochemistry is emphasized. Knowledge of these sciences as applied to clinical surgery will be required in the examination. Adequate operative experiences in which the candidate has assumed the whole responsibility will be required. An additional period of not less than two years of study or practice in surgery.

4. The candidate must present to the Board sufficient evidence of good moral character as to justify it in the belief that he will not engage in fee splitting and other dishonest practices.

It is expected that the Board, with the assistance and cooperation of the American Medical Association and the American College of Surgeons, will be able to increase the facilities which now exist for the adequate training of young surgeons by means of residencies, fellowships, etc., in suitable hospitals.

The above requirements, especially those referring to training, are subject to change from time to time as the existing opportunities for training in this field of specialization may be broadened.

The qualifying examination will be divided into two parts: Part I, written, and Part II, clinical, bedside and practical. The written part, Part I, will concern itself with general surgical problems and with the clinical application of the basic sciences of surgery to these problems. This examination will cover a period of three hours each and will be held simultaneously in as many centers as are necessary to accommodate the number of applicants who are eligible. Part II, is entirely oral and will also concern itself, in the main, with general surgery and, as stated for Part I, clinical application of the basic sciences to the clinical problem represented. In addition to this, in Part II, an examination will be given to test the candidate's knowledge of operative surgery, x-ray plate interpretation, and the principles and application of surgical anesthesia. This examination will be held in as many centers as the Board may determine necessary to accommodate the eligible candidates. Reexaminations will be allowed, provided one year shall elapse between examinations.

The fee for Group A, the Founders' Group, shall be \$25. The fee for Group B shall be \$75, payable as follows: \$5 for registration fee, which shall be returned if the candidate is not accepted for examination; \$20 for Part I; and \$50 for Part II. The same fee will be required for each reexamination. Once the candidate has become qualified, he will have no further financial obligation to the Board.

This Board is a nonprofit organization. All fees will be used, after a reasonable amount is set aside for necessary expenses in maintaining its office, conducting examinations, etc., to aid in improving existing opportunities for the training of the surgeon.

A certificate attesting to a candidate's qualifications in surgery after meeting the requirements of the Board will be issued, having been signed by its officers.

Any certificate issued by the Board shall be subject to revocation by the Board at any time in case it shall determine in its sole judgment, that a candidate, who has received a certificate, either was not properly qualified to receive it or has become disqualified since its receipt.

The Board will hold its first examination (Part I, written) on September 20, 1937. All inquiries concerning applications for this examination should be received by the secretary's office promptly.

Requests for booklets of information, application blanks, and other information should be addressed to the secretary, Dr. J. Stewart Rodman, 225 South Fifteenth Street, Philadelphia, Pennsylvania.

Syphilis and Gonorrhea.—The United States Public Health Service for the calendar year 1936 states:

Annual rates are per 1,000 population for venereal diseases in California cities with population of 200,000 or over.

This statement is issued for the information of health officers in order to furnish current data as to the prevalence of the venereal diseases. It is based on monthly reports received from city health departments.

City	Annual Rates Per 1,000 Population	
	Syphilis	Gonorrhea
Los Angeles	3.42	2.98
Oakland	1.52	1.60
San Francisco	2.47	2.52

This statement (for March, 1937) is issued for the information of health officers in order to furnish current data as to the prevalence of the venereal diseases. The following reports were received from State health officers. The figures are preliminary and subject to correction. It is hoped that this will stimulate more complete reporting of these diseases.

State	Syphilis		Gonorrhea	
	Cases Reported During Month	Monthly Case Rates Per 10,000 Population	Cases Reported During Month	Monthly Case Rates Per 10,000 Population
California	2,362	4.19	1,931	3.42
United States	32,402	2.59	15,166	1.21
City				
Los Angeles	579	4.04	414	2.89
Oakland	40	1.32	36	1.19
San Francisco..	129	1.92	144	2.15

Vienna to Have an International Congress of Short-Wave Specialists.—Doctors D'Arsonval and Zenneck, and Senator Marconi on Committee of July Congress.—From July 12 to 17 the scientific workers in one of the most rapidly advancing fields of physics, chemistry, biology, and medicine will convene in congress in Vienna, under the patronage of official Austria as represented by a committee including the Federal President, the Austrian Chancellor, the Rector of the celebrated University of Vienna, the Rector of the Vienna Technical College, and the Mayor of the City of Vienna. The congress sessions will be comprised of lectures by world-famous scientists followed by brief readings given by members, and general discussions. The papers read by members must not take more than fifteen minutes' reading time. Those wishing to read papers are requested to file a special application. The languages admitted are English, German, French, and Italian. The major papers read, as well as those presented by members, will be printed in full and copies distributed to those attending the congress, provided applications are received in time. In conjunction with the congress an exhibit showing the latest advances in the short-wave field, both in the abstract field and the field of applied practice, will remain open throughout the congress.

The subjects to be dealt with include: physics, biology, chemistry, and medicine. In the field of physics the subjects to be covered are: the properties of short waves and ultra-short waves; generation, conduction, radiation, and propagation; reflection refraction, absorption; measurement of SW and USW. Exploration of Heaviside-Appleton layers of the atmosphere. Chemistry and physical chemistry will be thoroughly explored in its relation to short-wave work and the practical aspects of short-wave application in the physical field will be treated extensively.

In biology the action of short waves of various types on plants, animals, organisms, enzymes, and ferments; heat effect and size particles; percutaneous SW diathermy; destruction of noxious insects; experiments will be included.

In the medical field, the connection of which with short-wave therapy has aroused world-wide interest, the following topics will receive attention: indications and counter-indications for the therapeutical application of SW and USW. USW therapy, its application in cases of acute inflammations of bacterial genesis in internal medicine, surgery, gynecology, dermatology, ophthalmology, otiatry, and neurology; SW therapy in connection with acute infectious diseases, especially with poliomyelitis acuta; sensibilization by SW of malign neoplasms refractory to x-rays; SW diathermy, its application in cases of chronic rheumatic diseases of joints and muscles; the technical side of apparatus.

All lectures and discussions will take place in the morning, leaving the afternoons free for demonstrations, experimental work or sight-seeing tours. Membership fee of the congress is thirty Austrian shillings, which fee includes the cost of all printed reports. The fee is payable in the local currency to the official Austrian representatives abroad. A crowded calendar of social events, including official receptions and merry excursions, has been planned to supplement the serious work of the members of the congress.

Programs and application blanks will be furnished upon request by applying to Austrian State Tourist Department, Publicity Service of the Federal Ministry for Commerce and Traffic, 630 Fifth Avenue, New York City.

Federal Grants for Public Assistance.—Federal grants totaling \$4,457,496.15 for public assistance in California, Connecticut, Idaho, Massachusetts, Michigan, Minnesota, New Mexico, Pennsylvania, and Washington were recently announced by the Social Security Board.

The amounts allotted, the form of assistance and the period of time for which each grant was made, and the number of individuals being aided under each plan in April, according to estimates based on reports received for the past thirteen months, are shown in the following table:

State	Aid to	Grant	Estimated Number of Recipients	Period Covered
California.....	Aged	\$806,688.21	70,500	April
California.....	Blind	189,628.33	4,620	Apr. 1-June 30
California.....	Children	90,438.64	21,600	Apr. 1-June 30

University of California Physician Will Head American College of Physicians.—Dr. William J. Kerr, head of the department of medicine, University of California Medical School, has been nominated as president-elect of the American College of Physicians, now meeting in St. Louis, it was announced recently by Dr. Langley Porter, Dean of the Medical School.

As Doctor Kerr was the only one nominated for the post, his election now becomes a matter of routine.

Doctor Kerr is also president of the American Heart Association, composed of heart specialists throughout the country. This Association will hold its annual convention in June in Atlantic City.

Doctor Kerr joined the faculty of the Medical School in 1916, and was acting head of the medical department from 1922 to 1927. In the latter year he was made full professor of medicine, and simultaneously became head of the department.

Use of Insulin for Dementia Praecox Increasing.—The use of insulin in the treatment of cases of dementia praecox that can be relieved by no other means, is being gradually expanded in the hope that the satisfactory results that have been achieved to date will at least be continued. This statement was made by Dr. C. H. Best, professor of physiology in the University of Toronto, and one of the four codiscoverers of insulin, while on a recent visit to the University of California.

A number of the mental hospitals in Canada are now using the insulin treatment, Doctor Best said. While apparent cures have been effected in a number of cases, and partial relief afforded in others, the percentage of failure is in such volume that no definite conclusions can be made for the treatment at this time. The treatment, which was first tried by Doctor Sokel in Austria, is but two years old. It consists in giving the patient a much heavier dose than would be given in a case of diabetes, causing reactions that directly affect the brain centers.

Doctor Best was one of the first to see the virtue in this new use of insulin, and he is watching developments closely. He is also taking a very direct interest in the development of protamine insulin, a compound which permits a diminution of the usual insulin dosage with generally more satisfactory results.

Working with Dr. Frederick Banting (later knighted), and Dr. J. R. Macleod, Doctor Best produced insulin for the first time in 1921. A few years later Dr. J. B. Collip so refined the substance that it could be used on humans without local irritation. All true insulin now used in the United States is standardized at Toronto before being distributed.

Physical Therapy Seminar at Los Angeles, June 17.—

The fifth annual mid-year session of the American Congress of Physical Therapy, Western Section, and the Pacific Physical Therapy Association will be held in the Los Angeles County Medical Association Building on June 17. All members of the California Medical Association and their technicians are cordially invited to the morning, afternoon, and evening banquet sessions.

National authorities on latest physical therapy developments, including Dr. Frank H. Krusen of the Mayo Clinic, Rochester, Minnesota, will appear on the program. Interesting exhibits will be displayed and topics fully discussed by California practitioners. Reservation may be made through W. W. Worster, M. D., San Gabriel, Chairman, or Clinton D. Hubbard, M. D., Huntington Park, Secretary of the Seminar Committee.

A complete program, now on the press, will be mailed upon application to Clinton D. Hubbard, 2504 Gage Avenue, Huntington Park, California.

Ingenious Medical Mechanic Uses Old Airplane Parts.—

A great many people use airplanes to fly around in, but August Kern, bracermaker in the University of California Medical School, uses them for an entirely different purpose. Within the past few months he has been able to fashion a number of braces and other hospital gadgets out of the fine metal and tubing from discarded airplanes, and there has been a wide demand for his products on the part of both doctors and patients.

Kern has found that airplane tubing, because of its light weight and its high tensile strength, makes particularly satisfactory braces. His working quarters are an odd assortment of vices, punching machines, emery wheels and air blowers, but they also contain many fine tools that Kern can handle with a watchmaker's precision. The brace-maker is himself a graduate physician, having obtained his M. D. from the University of Heidelberg, Germany. He practiced for a short time, but found that his skill in the making of surgical appliances and casts was in considerable demand, and he applied himself thereafter solely to the mechanical side of medical development. It is his hope to return to Germany some time and display some of his many successful appliances before the scientific societies there.

New Department of Visual Instruction Opens in Los Angeles.—

"Education cannot afford to lag behind in the utilization of inventions which experience has proved to be of value. Especially is this true of the motion picture, for there is much evidence to show that its possibilities can be even better realized in education than in the field of entertainment." With these words, Dr. Robert G. Sproul, President of the University of California, recently announced the opening in Los Angeles of a new Department of Visual Instruction, by the University Extension Division.

The new department was established in accordance with a recent action of the regents of the University who appropriated \$27,000 to create and stock a film center containing five thousand films for use by Southern California schools. The new center will be equal in all respects to the one on the Berkeley campus of the University, which has been serving the State for twenty years.

"Motion pictures enable the teacher to picture concretely those facts and ideas which would otherwise be vague abstractions to the student; and they enable teachers to present subjects in the best possible setting rather than in that which the average classroom provides. It is with these facts in mind that the University Extension Division has sought to meet the increasing demand for motion pictures by establishing distribution offices and visual-education libraries at both Los Angeles and Berkeley. The Department of Visual Instruction exists, primarily, to serve the schools of the State, and we hope to keep that service dynamic. Through conferences and discussions it is our desire to meet the needs of the schools as rapidly as they are worked out and reduced to specific terms."

The new department, with offices at 815 South Hill Street, in Los Angeles, is now booking for the fall school term, according to Professor Leon J. Richardson, Director of the Extension Division. The department will serve thirteen southern counties and the states of Arizona and New Mexico, Director Richardson said.

American Documentation Institute.—The American Documentation Institute has been incorporated on behalf of leading national scholarly, scientific and informational societies to develop and operate facilities that are expected to promote research and knowledge in various intellectual fields.

A first objective of the new organization will be to develop and apply the new technique of microphotography to library, scholarly, scientific and other material. It will be able to conduct scholarly publication by various methods as required by cooperating organizations.

Organized as a Delaware corporation "not for profit" but for educational, literary and scientific purposes, the new organization resulted from a meeting attended by delegates from national councils, societies, and other organizations in Washington on March 13.

The board of trustees elected consists of Dr. Robert C. Binkley, Western Reserve University; Dr. Solon J. Buck, Director of Publications, National Archives; Watson Davis, Director, Science Service; Dr. James Thayer Gerould, Librarian, Princeton University Library; Dr. Ludvig Hektoen, Chairman, National Research Council.

Such a national organization was foreseen as an outcome of Science Service's documentation activities when they were begun in July, 1935, implemented with grants from the Chemical Foundation and conducted with the cooperation of the United States Naval Medical School, the United States Department of Agriculture Library, the Bureau of the Census, the Works Progress Administration, the Library of Congress, and other agencies.

Bibliofilm Service has been conducted by Science Service in cooperation with the Library of the United States Department of Agriculture as a service to research workers, and auxiliary publication through microfilm has been conducted by cooperation with leading scholarly and scientific journals. Science Service's documentation activities will be transferred to the new American Documentation Institute.

International Health Congress Scheduled During New York's World Fair in 1939.—

Plans are being made for the holding of an International Health Congress during the New York World's Fair in 1939, it was announced recently by Dr. Donald B. Armstrong, President of the National Health Council, 50 West Fiftieth Street, New York City. In a statement to the press, Doctor Armstrong explained that advantage will be taken of the fact that hundreds of noted medical specialists and public health authorities, representing many countries, will be visiting New York City at the time of the World's Fair. American and foreign specialists will be asked to deliver addresses on subjects of interest not only to professional groups, but to the general public as well.

The last health congress, such as the one scheduled for 1939, was held at Atlantic City in 1926. Plans for the 1939 sessions are being perfected by the National Health Council in collaboration with the World's Fair Advisory Committee on Medicine and Public Health, which is headed by Dr. Louis I. Dublin. The program will be related, as much as possible, to the exhibits on medicine and public health that will be on display at the World's Fair; and it is hoped that a permanent American Museum of Hygiene similar to the German Hygiene Museum in Dresden will be established in New York subsequently.

Arrangements will be made for a series of visits of inspection to the leading hospitals, clinics, health centers, medical organizations, sanitary institutions, and other places of interest in New York City and vicinity. Both the official and private agencies engaged in public health activities throughout the metropolitan area will be invited to assist the National Health Council in the entertainment of its distinguished foreign guests.

It is expected that speakers and exhibits will be concerned more with the problems and methods of preventing ills than with technical aspects of the treatment and cure of disease. Some of the subjects that will be discussed are indicated by the following list of active member agencies in the National Health Council: American Society for the Hard of Hearing, Inc.; American Heart Association; American Public Health Association; American Red Cross; American Social Hygiene Association; American Society for the Control of Cancer; Conference of State and

Provincial Health Authorities of North America; Maternity Center Association, National Committee of Health Council Executives; National Committee for Mental Hygiene; National Organization for Public Health Nursing; National Society for the Prevention of Blindness; National Tuberculosis Association.

The United States Children's Bureau and the United States Public Health Service are advisory members of the Council. The American Nurses' Association and the Foundation for Positive Health are associate members.

LETTERS

Concerning Mussel Quarantine by State Board of Health.

To the Health Officers.

MUSSEL QUARANTINE ORDER

A quarantine of all mussels from the ocean shore of California extending from the southern boundary of Los Angeles County north to the California-Oregon boundary, with the exception of the Bay of San Francisco, is hereby established.

All health officers and food inspectors are hereby instructed to enforce the provisions of this quarantine and to prohibit the taking, sale, or offering for sale, of mussels gathered in the district specified. This quarantine order shall be effective for the period June 1, 1937 to September 30, 1937.

Said action is taken for the preservation of the public health.

W. M. DICKIE, M. D.,
Director of Public Health.

May 26, 1937.

Concerning a proposed federal cancer law.

Los Angeles, May 21, 1937.

To the Editor:—Enclosed you will find a copy of a bill, H. R. 6767, which, after reading, I would explicitly request that you have your office return to me, as it is my only copy.

This bill was brought to our attention by Dr. James Percy, a member of the Executive Committee of the Los Angeles Cancer Society. This bill was discussed in executive meeting by this society last evening, and after an extended debate we felt that this bill, with its implied intent, should be brought definitely to the attention of the State Medical Association and also the Los Angeles County Medical Association. We do not know definitely when this will be presented to the Committee on Interstate and Foreign Commerce; however, newspaper statements three days ago were to the effect that the bill is now, or will soon be, in Committee. This, in turn, makes any action by the regular medical profession an emergency, if such is deemed expedient.

As secretary of the Los Angeles Cancer Society I have been appointed one of a committee of two to bring this bill before the attention of the Los Angeles County Medical Council. This meeting, however, is not to be held until the evening of June 7, and in conversation with Dr. E. Vincent Askey today, he suggests that I write you at once.

The Executive Committee of the Los Angeles Cancer Society feel that this legislation, if enacted and made a bill by Congress, will be another peg in the machine towards socialized and federal medicine. Heart disease could be made the next jump, or we might even say obstetrics, or any other branch of medicine which is not contagious, as is tuberculosis, syphilis and other venereal diseases, which the Government is now beginning to scoop up as they go merrily on their way to the federal control of our patients.

Having spent approximately nine years in the Medical Corps of the Navy, followed by twelve years in the Medical Reserve Corps of the Navy, I feel that I can foresee certain pernicious tendencies in a bill worded as this reads to me. Having seen certain naval dispensaries, situated in different cities in the United States, grow from one officer in charge to as high as twenty officers on duty ashore, in actual competition with the regular practice of medicine, I can easily anticipate another arm of an octopus build on

by performing this National Cancer Act, and placing it completely in control of the Surgeon-General of the Public Health Service. It is well to know that this Act, worded as it is, leaves one individual in complete control, which can, and undoubtedly will, be chiefly political, and the committee of six members appointed by the Surgeon-General will be given, by this Act, only an advisory capacity in the awarding of the \$1,000 gratuity offered annually to some outstanding research or clinical man. This committee apparently only being able to choose the men annually for the award mentioned in Section 6 (a) of the Act.

The bill, as you will note, was introduced by Congressman Maverick of Texas on April 29, 1937, and there will be a similar bill presented to the Senate.

Dr. Dudley Jackson, 1028 Nix Professional Building, San Antonio, Texas, writes to Doctor Percy that he has helped frame this legislation and has conferred with Surgeon-General Parran and other interested parties regarding the bill. Doctor Jackson writes that he is having the Texas State Medical Association endorse this bill. He also writes to Doctor Percy, "It will take outside pressure to put it over, and I know it fits in with your belief in cancer research."

Very truly yours,

C. HIRAM WEAVER, M. D.,
Secretary, Los Angeles Cancer Society.

Concerning a salesman of surgical instruments.

Los Angeles, May 14, 1937.

To the Editor:—Recently I purchased some instruments from a salesman by the name of Klein. At the time of purchasing the instruments I was under the impression, as a consequence of statements by Mr. Klein, that they were stainless steel and not chrome-plated. Subsequently, after further examination, I find that the instruments which I purchased are chrome-plated. I believe that they are of an inferior grade.

I believe this information ought to be brought to the attention of physicians in this State and, therefore, I request that it be published in CALIFORNIA AND WESTERN MEDICINE.

Respectfully yours,

JOHN P. LORDAN, M. D.
2007 Wilshire Boulevard.

Concerning opportunities for physicians to Bolivia.

TREASURY DEPARTMENT
UNITED STATES PUBLIC HEALTH SERVICE

Washington, May 14, 1937.

Dr. Walter M. Dickie
State Director of Public Health
San Francisco, California

Dear Sir:

It has been brought to the attention of the Public Health Service that the National Department of Health of Bolivia is seeking to secure the services of one or more experts in the fields of hygiene, malaria, venereal diseases, and tuberculosis.

Nothing is known as to the amount of salary that might be paid for such services, nor of the tenure of office. It is understood, however, that the salary would be commensurate with the ability of the man or men to be employed. It is also assumed that the Bolivian Government would be willing to make the necessary arrangements with respect to transportation to Bolivia, together with certain guarantees for return to the States in the event of termination of an individual's services. It should be noted, however, that a change in administration in Latin American countries not infrequently results in the abandonment of enterprises of this nature, the same as in other countries, and anyone contemplating the acceptance of such a detail should not give up a satisfactory position here until definite arrangements are made for the one in prospect.

The request of the Bolivian Government is being brought to your attention with the thought that you may wish to refer it to someone within your State who might possess the desired qualifications, together with an ambition for

foreign service. Anyone who might be interested in applying for a position in Bolivia is advised to communicate with Medical Director B. J. Lloyd, United States Public Health Service, Assistant to the Director, Pan-American Sanitary Bureau, Washington, D. C.

By direction of the Surgeon-General.

C. E. WALLER,
Assistant Surgeon-General, Domestic
Quarantine Division.

Concerning Hotel Del Monte appreciation.

Del Monte, May 14, 1937.

Dear Doctor Warnshuis:

It is most gratifying to receive a letter such as yours of May 13 and I wish you to know that I sincerely appreciate the kind expressions contained therein.

I have passed on your words of praise to the Department Heads mentioned in your letter and, naturally, they were all most pleased to know that everything in connection with the California Medical Association went off so successfully.

It was indeed a pleasure to have you all with us, and I hope that you will find it possible to hold another convention here soon.

With many thanks and kindest regards, I am

CARL S. STANLEY, *Manager.*

Hotel Del Monte.

Concerning the impressions of Guest Speakers at Del Monte.

UNIVERSITY OF MICHIGAN: UNIVERSITY HOSPITAL
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

Ann Arbor, May 14, 1937.

Dr. Frederick C. Warnshuis
450 Sutter Street
San Francisco, California

My dear Doctor Warnshuis:

Now that I am back facing reality again, I have plenty of time to meditate over the delightful meeting at California.

I was certainly impressed with the massive size of the State as well as the California Medical Association. Certainly, you people do things on a big scale.

As I told you just before I left, I am very grateful to the Association for inviting me out and want you to know that I enjoyed every moment of it.

Sincerely,

NORMAN F. MILLER, M. D.

✱ ✱ ✱

New York, May 12, 1937.

Dear Doctor Warnshuis:

I shall always remember with satisfaction the warm reception and cordial hospitality extended to me by the California Medical Association on my visit to Del Monte. You have accomplished a great purpose in uniting the medical profession and I congratulate you on the results of your efforts.

Very sincerely yours,

JESSE G. M. BULLOWA, M. D.

62 West Eighty-seventh Street.

Concerning California Medical Association's contribution to Lane Medical Library.

STANFORD UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF THE DEAN

San Francisco, May 17, 1937.

To the California Medical Association:—This acknowledges the receipt of check for \$1242.75 as the California Medical Association's contribution to Lane Medical Library for 1937. . . .

We are depending a great deal on such contributions, and it really gives us a chance to do things for doctors throughout the State which otherwise we could not do. The whole staff and the University join me in expressing our thanks.

Very truly yours,

L. R. CHANDLER, M. D., *Dean.*

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.

San Francisco

Requirements of California Minimum Wage Law as Applied to Professional Offices

In 1913, the California Legislature enacted a statute regulating the employment of women and minors and establishing an industrial welfare commission. This statute has subsequently become known as the "Minimum Wage Law."

After the decision of the United States Supreme Court in *Adkins vs. Children's Hospital*, 261 U. S. 525, in which the District of Columbia Minimum Wage Law was held unconstitutional, it was generally assumed that the California Minimum Wage Law was likewise unconstitutional. Last year when the Supreme Court held in *Morehead vs. New York*, 298 U. S. 587, that the New York Minimum Wage Law was unconstitutional, it was generally considered that all minimum wage laws, including the California Act, were beyond doubt unconstitutional.

On March 29, 1937, the United States Supreme Court by a five to four decision overruled the *Adkins* case and held that the Washington Minimum Wage Law is constitutional. This case, *West Coast Hotel Co. vs. Parish*, 81 L. Ed. 455, has received a vast amount of publicity, particularly in connection with a fundamental governmental issue which is now before the Congress of the United States.

The decision of the Supreme Court upholding the constitutionality of the Washington Minimum Wage Law is particularly significant with respect to the California Minimum Wage Law, because the Washington statute was also enacted in 1913 and in general contains practically the same provisions as are found in the California statute. It must, therefore, be assumed that since March 29, 1937, the California Minimum Wage Law has become a constitutional statute in so far as the constitutional questions considered by the United States Supreme Court in the Washington Minimum Wage Law case are concerned. With respect to the California Act, there is an additional constitutional question which has not received judicial construction as yet (in so far as this particular statute is concerned). The additional problem to which we refer is: Has the Legislature delegated legislative powers to the Industrial Welfare Commission? If the California Supreme Court should ever have this question before it and if it should decide that there has been a delegation of legislative power, the California Minimum Wage Law will, of necessity, be held to be in conflict with the California Constitution. However, considering that the California Minimum Wage Law has been in effect since 1913, it is not likely that an adverse decision with respect to delegation of power will be forthcoming. In any event, the powers granted by the Act to the Industrial Welfare Commission are not limitless and there is some precedent to justify the contention that no delegation of legislative power has been made. For all practical purposes, it is necessary to conclude that the decision of the United States Supreme Court in the Washington Minimum Wage Law removes all major doubts with respect to the constitutionality of the California Minimum Wage Law.

The recent turn of events in this field makes appropriate a consideration of the California Minimum Wage Law and a discussion of the rules and regulations issued by the Industrial Welfare Commission thereunder, particularly in so far as the rules and regulations relate to the medical profession. The California Act creates an industrial welfare commission of five members, at least one of whom shall be a woman. The Commission is given very broad powers. Possibly its most important powers are contained in Section 6 of the Act, which reads as follows:

The Commission shall have further power after a public hearing had upon its own motion or upon petition, to fix:

1. A minimum wage to be paid to women and minors engaged in any occupation, trade or industry in this state which shall not be less than a wage adequate to supply to such women and minors the necessary cost of proper living and to maintain the health and welfare of such women and minors.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, containing copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

2. The minimum hours of work consistent with the health and welfare of women and minors engaged in any occupation, trade or industry in this state; provided that the hours so fixed shall not be more than the maximum now or hereafter fixed by law.

3. The standard conditions of labor demanded by the health and welfare of the women and minors engaged in any occupation, trade or industry in this state.

The statute contains provisions making it a misdemeanor for any employer to violate orders of the Commission promulgated pursuant to Section 6, and then contains the following broad grant of power:

It shall be the duty of the Industrial Welfare Commission to enforce the provisions of this Act and compliance with its orders, rules and regulations. Full power and authority is hereby vested in the Commission to take such action as may be deemed essential for such purposes.

Stating that it is acting pursuant to the powers granted by it under the California Minimum Wage Law, the Industrial Welfare Commission has promulgated certain rules and regulations relating to employment of women and minors in general and professional offices. Inasmuch as the Commission is of the opinion that these rules and regulations apply to medical offices, a brief statement of the substance of the various rules is set forth herein for the convenience of members of the Association:

1. *"Employee" Defined.*—When the term "employee" is used in connection with the rules and regulations of the Industrial Welfare Commission, it means any woman or any minor, male or female, under eighteen years of age.

2. *Minimum Wage for Experienced Employees.*—The Commission requires employers to pay experienced employees a minimum of \$16 a week for work in any professional office.

3. *"Experienced Employee" Defined.*—An employee is deemed experienced after having worked for six months in any professional office. It is also provided that if an employee is transferred from one branch of an office to another branch of an office that the employee shall be credited with not less than twenty weeks' experience, unless the transfer is made to widely dissimilar branches of work, in which case the employee must be credited with not less than nine weeks' experience.

4. *Minimum Wage for Inexperienced Employees.*—

(a) Apprentices eighteen years of age and over: for the first three months, \$12 a week; for the second three months, \$14 a week; thereafter, not less than \$16 a week.

(b) For apprentices under eighteen years of age: for the first two months, \$10 a week; for the second two months, \$12 a week; for the third two months, \$14 a week; thereafter, not less than \$16 a week.

In connection with inexperienced employees or apprentices (the Commission apparently uses these terms interchangeably) the Commission has adopted the following rule:

No person, firm or corporation shall suffer or permit the employment of over 33½ per cent of the female office workers as apprentices at less than the legal minimum wage of \$16 a week.

5. *Minimum Wage for Part-Time Workers.*—(a) For a part-time employee over eighteen years of age or for a part-time experienced employee under eighteen years of age, the minimum wage is fixed at forty cents an hour. It is also provided that the wages paid in one day of eight hours or less need not exceed \$2.67.

(b) An inexperienced part-time employee under eighteen years of age may be employed as a part-time worker at less than forty cents an hour, but not less than thirty cents an hour. It is provided that the wages paid in any one day of eight hours or less need not exceed \$2.

6. *"Part-Time Worker" Defined.*—A "part-time worker" is defined as an employee who works less than eight hours in any one day.

7. *Minimum Wage for Special or Temporary Workers.* (a) A "special worker" or "temporary worker" is defined by the Commission as a person employed on a temporary basis and for less than two weeks.

(b) Such an employee, if over eighteen years of age or if an experienced employee under eighteen years of age, must be paid at least \$2.67 for a day of eight hours.

(c) Such an employee, if inexperienced and under eighteen years of age, must be paid not less than \$2 for a day of eight hours.

8. *Permit for Handicapped Workers.*—The Commission may, if requested, issue a permit authorizing the employment of a person handicapped by reason of age or disability at a wage less than the minimum wages above set forth.

(a) Female employees over eighteen years of age who receive more than \$30 a week and who are not subject to the provisions of the eight-hour law for women (this statute includes hospitals, but does not include medical offices) may be employed for more than forty-eight hours a week in cases of emergency.

(b) Female employees over eighteen years of age who receive less than \$30 a week and who are not subject to the provisions of the eight-hour law for women, may be employed more than forty-eight hours a week in cases of emergency, provided that all work performed in emergency cases shall be paid at a rate of wages not less than time and one-half the rate paid in regular time.

(c) Persons under eighteen years of age may not be employed before the hour of 6 a. m. or after the hour of 10 p. m. or more than eight hours in any one day or more than six days in any one week.

(9) *Meal Periods.*—A meal period of not less than one-half hour must be given to all employees after not more than five hours of employment. The employer is responsible for seeing that this time is taken.

10. *Records and Reports.*—An employer is guilty of a misdemeanor unless he keeps a record of all employees, showing the hours worked daily, and the wages paid. Male minors under eighteen years shall be marked "M," and female minors under eighteen years of age shall be marked "F" on the pay roll. Upon request of the Division of Industrial Welfare, employers are required to file verified reports containing such information as is required by the Division.

11. *Cash Shortages.*—The rules of the Commission provide that no employer may deduct from the minimum wage of an employee on account of a cash shortage unless it is shown that the shortage is caused by the wilful or dishonest act of the employee, notwithstanding any contract or arrangement to the contrary.

The foregoing rules and regulations are contained in Industrial Welfare Commission, Order No. 9, as amended. Readers who are familiar with the general principles of constitutional law and who are familiar with the political theory of the Republican form of government under which we are supposed to be living, will no doubt be startled by the following rule promulgated by the Industrial Welfare Commission:

The Commission shall exercise exclusive jurisdiction over all questions arising as to the interpretation of this order.

Needless to say, we have not as yet granted all powers of government, viz., legislative, executive and judicial, into the hands of one individual or group of individuals. The Industrial Welfare Commission has promulgated its Order No. 9, i. e., it has legislated, it proposes to enforce the provisions of its order, i. e., it intends to act in an executive capacity, but one may be permitted to doubt that it will be able to sit in final judgment over all disputes arising under its legislation.

Chemical Society Hears of Recent Research by United States Department of Agriculture Scientists.—A new method of chemical analysis, so sensitive that it detects as little as a millionth of a millionth of a gram of potassium in the tissues of plants and animals, was one of several developments described by scientists of the Bureau of Chemistry and Soils, United States Department of Agriculture at the spring meeting of the American Chemical Society at Chapel Hill, North Carolina, April 12-17.

The extreme sensitivity of this method of analysis makes it possible to test the uniformity of atomic weight of potassium in ocean water down to two and one-half miles in depth. Observations by the new method show the atomic weight of potassium in plant tissues to be practically uniform throughout. Kelp is found to contain an abnormal abundance of the radioactive constituent of potassium, while the atomic weight of potato vines becomes heavier as the plant matures. The new method was developed by Dr. A. K. Brewer.

SPECIAL ARTICLES

CUBA: HEALTH-INSURANCE TEST-TUBE.*

Doctors Dislike Mutual-Benefit Societies;
Run Own Clinics

Last week [April 20, 1937] after spirited debate, the New York State Assembly passed the Fite Bill, which entitles every mother, married or unmarried, citizen or alien, to claim a contribution of \$75 from the State toward the expense of childbirth. . . . Passage of the measure by the Senate is problematical, but the bill serves as a straw in the wind blown up by the recent survey of American medicine by the American Foundation,¹ indicates that the reëxamination of problems involved in distributing medical care is reaching the stage of legislative ferment.

* * *

As a phase of social-security agitation, discussion of the relationship between patient and physician usually revolves around the compulsory health-insurance laws of European countries. Conflicting conclusions are drawn from European experience. Less well known is the system of coöperative medicine which has been operating in Cuba for fifty years.

The tight little isle in the Gulf, just a plane's-throw off the Florida Keys, constitutes a medical microcosm which reveals the evolution of medical care along lines of national necessity. Since a weighty section of medical opinion in this country believes that medicine should not be confined by social legislation, but should follow a process of natural evolution, the Cuban experience is worthy of examination as a novel case history of the course evolution sometimes pursues.

ACTION

With a Latin leaning toward direct action, Cuban patients and physicians have fought out their problems in a manner without the remotest American parallel. Drama reached a high pitch which included such startling exhibitions as a march of fifty thousand citizens on the Capital, a walk-out of doctors, the kidnaping of surgeons by frantic relatives who forced them to perform operations at the point of a gun. The situation still seethes and simmers, but overt expression is restrained by the powerful Colonel Fulgencio Batista.

Spanish immigrants flocking to the new and unexploited land of Cuba in the years between 1880 and 1898 were for the most part clerks, laborers, waiters, financially submerged in a strange country with only the most primitive educational and medical facilities. Unable to pay for doctors or hospitals, the people found sickness an overwhelming catastrophe. To meet this situation, colonials hailing from the same provincial regions of Spain formed mutual-benefit societies.

Originally these organizations used their funds merely to buy clubhouses and to send their members to hospitals when they fell ill.

Big three of the mutual-benefit societies are the *Centro Gallego*, oldest of them all, founded by Galicians in 1879; the *Centro Asturiano*, founded in 1886; and the *Asociación de Dependientes del Comercio* (Association of Commercial Employees), organized in 1880 and one of the first to throw its doors open to native Cubans and foreign residents. In addition to these there are a half-dozen smaller regional societies, some twenty-five native Cuban organizations patterned on the same model.

Today these mutual-benefit societies provide much more than medical care. They offer the facilities of a social club,

run employment bureaus, give legal advice, have established schools and libraries.² But, most important, they have built some of the largest and best-equipped hospital centers, or *quintas*. These are small cities in themselves, which may have from one to thirty pavilions, each dedicated to a special branch of medicine. *Quinta Covadonga*, which belongs to the Asturian Center, has thirty pavilions which include a nurses' training school, interns' residence hall, a chapel, carpentry shop, pharmacy, workshop to make uniforms, gowns, and linens.

Centro Gallego spent \$2,000,000 in 1915 erecting an administration building facing the *Parque Central* in the heart of Havana. Across the park, *Centro Asturiano* has a Spanish baroque structure rivaling the Cuban Presidential Palace in architectural swank. The Association of Commercial Employees also has spacious headquarters in Havana, equipped with gymnasium, schoolroom, library, and ballroom.

Whence comes this financial potency? The \$2 monthly fee of members provides the funds. For this, members are entitled more than medical care: After twenty-five years a member can enter the old-age home maintained by most of the societies and be taken care of for the rest of his life. Often burial expenses are defrayed. Patients requiring a change of climate are entitled to third-class passage to any destination a doctor may deem beneficial and \$700 in cash. Members may use game rooms, libraries, attend social functions, send their children to society schools. For minor ailments a member can obtain free medicine when prescribed by a staff doctor.

A typical example of what the member gets for his \$2 a month dues is seen in the case of an appendicitis operation. A nonmember requiring such an operation at one of the *quintas* would pay a minimum fee of \$170, budgeted about as follows: Hospital room for seven days, \$35; operation, \$100; operating room, \$10; food, \$10; nurse, \$15—total, \$170.

This all comes to the member by virtue of his nominal monthly payment. Many members could not possibly meet such a lump-sum payment as \$170; other members, more healthy or wealthy, never demand benefit privileges—a large percentage of well-to-do members pay their contributions year after year, but call a private doctor when they fall ill.

Most Cuban mutual-benefit societies admit anyone not more than fifty years of age, not suffering from an incurable disease, not a Negro or Chinese. Until five years ago, women, more likely to require medical attention, were not admitted by most societies; now several associations exclusively for women exist. The Chinese, of whom there are some 25,000 in Cuba, have their own societies, such as the Kow Kong Association, but Negroes, comprising 27 per cent of the population of the island, must rely on public hospitals for medical care.

Not solely dependent on application of the insurance principle, the democratic managers of the societies are financially canny, augment association funds by commercial enterprise. Funds are carefully invested. *Centro Gallego* runs a savings bank, owns and operates one of the largest theaters in Havana. Barber shops, cigar stores, and restaurant concessions in club buildings bring in rental fees. Industries buy accident insurance for employees from the societies.

Yet, there are several darkening clouds on the financial and political horizons. Membership has been curtailed by the depression. Some smaller societies (such as *La Asociación Canaria*, whose membership dropped from 40,000 to 3,000) are in bankruptcy.³ The larger associations have carried on their work, however, more or less as usual. Last

* Reprinted, by permission, from *The Literary Digest* of May 1, 1937. Copyright, 1937, by Funk and Wagnalls Company, New York.

Readers of CALIFORNIA AND WESTERN MEDICINE who are interested are referred to CALIFORNIA AND WESTERN MEDICINE, February, 1932, pages 116 and 139, in which the topic "Health Insurance Societies of Cuba—Pseudo State Medicine and With a Vengeance" was editorially discussed. On page 141 of that issue appeared a full page of illustrations of the "Centro Asturiano."

¹ See "Medical Care, Economics Debated," *Literary Digest*, April 10. [Also May issue, CALIFORNIA AND WESTERN MEDICINE, page 292.]

² Public schools have been closed in Cuba for the last seven years because of political unrest. Mutual benefit societies have performed an important service in educating children of the poorer classes whose parents cannot afford private schools. Primary education, day and night classes for adults, courses in typewriting, accounting, music, art, sewing, etc., are provided.

³ Predepression membership figures were as follows: Centro Gallego, 64,000; Centro Asturiano, 60,000; Association of Commercial Employees, 52,000. Total number of societies runs well over forty. At its peak period, half the population of Cuba belonged to one of the mutual benefit societies.

year the Association of Commercial Employees, with a membership of 25,255, conducted 1,094 operations (with only sixteen deaths); made 12,446 visits to patients' homes; gave 295,460 consultations at the *quinta*; took care of 5,195 hospital cases.

Principal hazards of the mutual-benefit societies are hostile propaganda and doctors' strikes. During the past decade, growing opposition to the societies has arisen within the medical profession; physicians view the benefit associations as an economic threat. In 1934, the population of Cuba was 3,420,184. At that time there were 1,342 physicians, or one doctor for every 2,550 inhabitants. But 1,200 of these were located in Havana, a city whose population is 592,500, so the Capital had one doctor for every 494 persons. There is plenty of medical work to be done in Cuba, but chiefly among people who cannot pay for it. Cuba has more physicians than it can support.

Attributing their economic plight to the existence of the *quintas*, physicians maintain that the societies have wrecked profitable private practice, giving medical service for \$24 a year to patients well able to pay the fees of a private practitioner.⁴

ONE TO FORTY

Quintas are required by law to have at least one doctor for each forty patients. Average staff of doctors in the larger *quintas* is about fifty, working on a part-time basis, two or three hours a day, three or four days a week. The rest of their time is available for private practice. *Quinta Covadonga of Centro Asturiano* has a staff of 350, with the following monthly pay scale:

Director of the *quinta*, \$420; resident doctors, \$105; laboratory head, \$157; bacteriologist, \$62.50; chief doctor of each pavilion, \$157.50; pharmacist, \$132.50; nurses, \$56.45; nose and throat specialist, \$157.50; visiting doctors, \$137.50; chiropodist, \$69.30. The standard of living in Cuba has fallen considerably in recent years and these figures must be considered in the light of the fact that the middle-class white-collar worker earns about \$600 a year, lives comfortably on it; those in well-to-do circumstances manage nicely with incomes of \$1,000 to \$2,000 a year. Food and rents are extremely low.

First inkling that pressure was getting too great for the safety valve came in 1926. Doctors, bent on fighting the mutual-benefit societies, formed the Medical Federation of Cuba, demanded that the societies be limited to lower-income groups—single men with incomes of less than \$1,000, married men earning less than \$1,500. The societies resisted, maintaining that their greatest source of income were wealthier members who paid, but rarely used, *quintas*.

FLOP

A strike was called against *Centro Gallego* in 1926, lasted thirty-three weeks, left a tense situation which cracked in August, 1932, when the Medical Federation issued an ultimatum: All physicians would be withdrawn from the staffs of mutual-benefit society hospitals unless all members capable of paying for medical services were dropped. Five hundred doctors walked out, spurned mediation efforts of the Machado Government, expelled one hundred physicians who disapproved of the strike, left 2,440 hospital patients without medical attention. Public opinion rallied against the doctors and their strike flop.

In 1933, the deep-rooted wound suppurated again. Cuba was torn with disorder, communist agitation; *quintas* were losing membership because strict national labor laws, favoring native Cubans, were driving their Spanish members back to Spain in droves. Again the Medical Federation threatened a general strike. This time, the mutual-benefit societies beat the doctors to the draw. Fifty thousand society supporters paraded to the Presidential Palace on September 27, 1933, stood in a drizzle and gave mannerly protest against President Ramon Grau San Martin's decree requiring all physicians to join the new Medical College of Cuba.

The crowd had its way when the decree was suspended on October 2, but an ugly situation developed in January,

1934, when the closing of all the Spanish mutual-benefit societies seemed imminent. The society presidents had recommended such action to their boards unless the Government restored the right to practice to those sympathizers of the associations who had been expelled from the National Medical College.

CHAOS

Promptly, the doctors called a general strike on January 19. In an amazing demonstration, doctors, nurses, interns, and hospital employees, some 25,000 in number, walked out all over the island. Critically ill patients were abandoned, equipment was destroyed, general panic ensued. Relatives and friends flocked to hospitals to care for suffering and dying patients. Surgeons were kidnapped at gun's point by frantic husbands and fathers, forced to attend patients. The Army occupied the hospitals and strike-breaking physicians, nagged on by the shade of *Esculapius*, risked their lives to save as many patients as they could. Reaction of the public was direct, primitive; doctors were bitterly condemned as bent on destroying the societies for selfish motives, forcing the public to pay exorbitant medical fees. The doctors were supported by the Cuban Conference of Labor, the island's most radical union, by Leftist students, by the faculty of the University of Havana, which resigned in sympathy with the physicians.

Disorder continued; health officers inspecting the hospitals were attacked despite heavy military guard. For three days embattled doctors and public fought lustily until the Army stepped in and forced order. On February 17, President Mendieta dissolved the National Medical College, which had called the strike.

Since then there have been no outbursts, chiefly because Colonel Batista will not tolerate public disorder. The doctors started fighting fire with fire, have established *quintas* of their own. Some two dozen have sprung up within the past two years, patterned after the mutual-benefit societies, but operated by doctors as commercial enterprises.

WHAT CAN A TEACHER DO FOR A CHILD WITH HEART DISEASE*

A child suffering from chronic heart disease is as much crippled as a child who has been partially paralyzed, sometimes more so. The child who is partially paralyzed from infantile paralysis enlists more sympathy from those around him than a child with a heart condition. Still, the child with a heart disease may suffer more disability and nervous strain than any other child, and his parents, teachers, and friends may be unaware of his condition.

For over ten years the Los Angeles City Schools have had a special program for all children with heart disease. A great number of school children with heart conditions have been examined by a board of heart specialists who outline a general program for them in coöperation with the family doctor, the parents, and the teachers. The remaining children are examined by the school physicians.

The parent, the doctor, and the teacher coöperate in guarding these children's activities. Many of the children's lives are prolonged through this guidance. They are educated along the proper vocational lines and become useful citizens in spite of their handicaps.

In the Los Angeles City Schools, children with heart disease are classified into four groups patterned after the classification of the American Heart Association. Most of the children are placed in corrective classes where they are given exercises and rest.

The teacher's part in guarding these pupils from becoming permanently disabled is of the greatest importance. The teacher who has children with heart diseases in her classes should remember that these children are often of a highly nervous temperament, which indirectly affects their heart condition. Therefore, these children should be favored in regard to recitations, coming late to class, and reprimands. The child with heart disease should be asked the first question so that he will not have to sit and wait for the question to be asked, as such suspense indirectly affects the nerve

⁴ The Medical Federation holds that 25 per cent of the membership of mutual benefit societies could pay for medical care; the societies put the figure at 10 per cent.

* By Sven Lokrantz, M. D., Director of the Health Service Section of the Los Angeles School District.

mechanism of his heart. The child with heart disease should never be exposed to ridicule or reprimands. If a child with heart disease needs correction, the teacher should take the child privately aside and talk to him. The teacher should watch and see that the child with heart disease is given his rest period at noon. Special arrangements should be made for tardy slips when the child has to walk to school and where buildings are far apart. In severe cases, programs should be lightened. The health cards should be inspected and checked to see whether the children have infected tonsils that have been recommended for removal or whether any other chronic infections are present.

A very warm or drafty classroom is detrimental to a child with heart disease because this type of child is very susceptible to colds. Every cold means more infection and an infection may mean future weakening of the heart muscle. If a child with heart disease looks ill, the teacher should investigate the circumstances, send the child home and notify the school physician or the school nurse.

In all that you do, try to avoid the suggestion of invalidism. It is a great mistake to make any child too heart conscious, as he may become a chronic neurotic when he becomes an adult and be a burden to himself and to society.

It is far more important to pay attention to the physical condition of the child with heart disease than to his education.

VOLUNTARY HOSPITAL INSURANCE PLANS APPROACH ONE MILLION MEMBERS*

Nonprofit Plans for Budgeting Hospital Bills Report Threefold Increase in Membership and Greater Financial Stability During Past Year

Voluntary hospital insurance plans, by which workers and their families budget their hospital bills through monthly payments equal to two or three cents a day, reported an enrollment of approximately 900,000 subscribers April 1, 1937. This is to be compared with an estimated enrollment of 800,000 persons a year ago.

The membership is distributed among seventy-five different organizations in various parts of the United States, including New York City, Washington, D. C., Chicago, Cleveland, Minneapolis, St. Paul, New Orleans, Sacramento, Buffalo, Rochester, N. Y., Syracuse, Newark, Dallas, Houston, as well as smaller communities in the southern and western states.

Most of the growth has occurred among nonprofit free-choice plans of the type sponsored and recommended by the American Hospital Association. Thirty-three such associations have enrolled 750,000 members in eighteen different states, where they are supervised and regulated by the state departments of insurance or are organized under the general laws covering nonprofit corporations. Plans operated by individual hospitals and private promoters and industrial enterprises report approximately 125,000 subscribers, which is essentially the same number as were enrolled twelve months previously. These figures do not include an additional 75,000 enrolled by industrial firms or labor unions exclusively for their own membership, or the various plans of contract practice or insurance covering both hospital and medical services.

During the past three years many plans have been under discussion, but not actually placed in operation. The files of the American Hospital Association contain information of at least one hundred such plans which were discontinued before they reached the stage of actually enrolling subscribers. Four single-hospital plans have been discontinued because of local professional opposition of lack of community interest. In addition, a number of privately owned plans have stopped their activities because of conflicts with insurance law requirements or difficulties of interesting prospective subscribers.

In no instance has a nonprofit free-choice hospital service association been discontinued. The enrollment in these

organizations is increasing from month to month, hospitals have been paid promptly for services to subscribers, and reserves have been established by initial deposit or accumulation of earnings to meet the requirements of insurance departments or sound business policy.

Voluntary hospital care insurance is not a panacea for the problems of hospital finance; moreover, hospital insurance is not a complete answer to the public's request for a plan of budgeting the costs of sickness. Experience has demonstrated, however, that hospital service plans which are established with primary emphasis upon public welfare have also been economically sound in their relations with subscribers and hospitals.

During the year 1934 the insurance laws of the State of New York were amended to permit the formation of nonprofit hospital service corporations, to be governed by special regulations of the departments of insurance and social welfare. The following year, similar acts were enacted by the legislatures of Alabama, California and Illinois, and in 1937, permissive legislation has been passed in the states of Georgia and Maryland which place nonprofit hospital service corporations directly under the supervision of the departments of insurance.

The American Hospital Association does not recommend the establishment of hospital service associations unless they meet the standards of the Council and trustees of the Association established in February, 1933. These standards are: emphasis on public welfare; nonprofit sponsorship and control; free choice of hospital by subscriber; limitation of benefits to hospital service; representation of community and professional interests; economic and actuarial soundness; dignified promotion and management.

The largest membership has been reached by Associated Hospital Service, Incorporated, of New York, which enrolled more than 350,000 subscribers during the first two years of its life ended May 1, 1937. Next largest is the plan conducted in Minneapolis and St. Paul, which reports 85,000 after four years' activity. Other growing plans have enrollment as follows: Rochester, New York, 65,000; Cleveland, 50,000; New Orleans, 40,000; Washington, D. C., 35,000; Durham, North Carolina, 26,000; Chapel Hill, North Carolina, 23,000; Newark, New Jersey, 20,000; Sacramento, California, 16,000.

April 1 (1937) Enrollment of Non-Profit Hospital Service Plans Which Have Been in Operation Twelve Months or Longer

<i>Location of Headquarters</i>	<i>Employed Subscribers</i>	<i>Dependents</i>	<i>Total</i>
Birmingham, Alabama	5,632	4,476	10,108
Sacramento, California	10,454	5,227	15,681
San Jose, California	557	550	1,107
Norwalk, Connecticut	3,596	1,041	4,637
Wilmington, Delaware	4,715	2,328	7,043
Washington, D. C.	35,000	none	35,000
Ashland, Kentucky	3,765	2,714	6,479
New Orleans, Louisiana	13,378	26,298	39,676
St. Paul, Minnesota	40,429	42,951	83,380
St. Louis, Missouri	7,013	none	7,013
Newark, New Jersey	14,502	5,725	20,227
Geneva, New York	830	130	960
New York City	186,143	97,316	283,459
Rochester, New York	35,129	29,015	64,144
Syracuse, New York	10,796	none	10,796
Chapel Hill, North Carolina.....	15,000	7,975	22,975
Durham, North Carolina	13,500	13,000	26,500
Cleveland, Ohio	44,401	5,833	50,234
Easton, Pennsylvania	3,200	3,100	6,300
Kingsport, Tennessee	2,349	4,439	6,788
Norfolk, Virginia	4,126	2,313	6,439
Richmond, Virginia	2,887	none	2,887
Bluefield, West Virginia	4,094	6,485	10,579
Charleston, West Virginia	3,610	6,173	9,783

Other nonprofit hospital service associations formed since April 1, 1936, are located at Oakland, California; New Haven, Connecticut; Chicago and Peoria, Illinois; Albany, Buffalo, Jamestown and Utica, New York; and Akron, Ohio.

* Issued by C. Rufus Rorem, Director, Committee on Hospital Service, American Hospital Association, Chicago.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. X, No. 6, June, 1912

From Some Editorial Notes:

Be Ye Humane.—Doctor Huntington, in the closing paragraphs of his presidential address, says: "... those interested in medicine, as teachers or students, should be admonished regarding a sentiment which is of exceeding import and finds expression in the command, Be ye humane. With propriety these words, which suggest the spirit and the substance of the humanities, might be written upon the portals of every school and hospital." ...

~ ~ ~

A Secretary's Views on Dues.—In view of the fact that membership dues in most of our county societies are payable in advance, it would seem rational to suppose that members would be only too glad to remit the amount of their indebtedness immediately upon receipt of their society's bill. Nevertheless, getting members to pay their dues has been for many years the most arduous task of the county society secretaries. The San Francisco County Medical Society, up to a little over two years ago, employed a regular collector, who made it his business to stir up the careless and hold-back variety until the dues were paid, and he pocketed 20 per cent as his fee. ...

Minutes of the House of Delegates of the Medical Society of the State of California, Forty-Second Annual Meeting.—The House of Delegates was called to order at 8:45 p. m., April 16, 1912, Del Monte, by the president, Doctor Huntington. ...

* * *

Eye, Ear, Nose and Throat Section.—C. F. Welty presented the following request from the San Francisco County Society, which was referred to the Reference Committee:

San Francisco, Cal., March 16, 1912.

To the House of Delegates of the Medical Society of the State of California.

Gentlemen—The Eye, Ear, Nose and Throat Section of the San Francisco County Medical Society, respectfully request that you create a section, to be known as the "Eye, Ear, Nose, and Throat Section of the Medical Society of the State of California."

Respectfully submitted,

William F. Blake, *Chairman.*

Approved by San Francisco County Medical Society.

René Bine, *Secretary.*

* * *

Change in Medical Law.—The following was introduced by George H. Kress and referred to the Reference Committee:

April 12, 1912.

To the House of Delegates of the Medical Society of the State of California.

Gentlemen—The Board of Councilors of the Los Angeles County Medical Association respectfully request that the House of Delegates of the Medical Society of the State of California take steps at the Del Monte meeting to consider a plan of action on the following propositions:

1. A state law in California, modeled somewhat after the California Dental and Pharmacy laws whereby an annual tax of two dollars would be levied on all licensed practitioners of the healing art in California, the money so raised from the said tax to be deposited in the State of

(Continued in Front Advertising Section, Page 15)

†This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.

Secretary-Treasurer

News

"Three members of the asserted illegal operations ring, exposed several months ago, obtained new trials by a ruling on file today in District Court of Appeal. The defendants were James Beggs, M. D., and Jesse C. Ross, M. D., convicted on five counts of conspiracy and performing illegal operations, and Valentine St. John, M. D. William A. Byrne, former special agent for the State Board of Medical Examiners, lost his appeal on four counts, while the fifth was dismissed as defective. The appeal of another defendant, R. L. Rankin, was dismissed recently at his own request. In the cases reversed Justice Marshall F. McComb, writing the opinion, based it upon the law that a conviction cannot be sustained on the testimony of an accomplice unless corroborated by other evidence." (Los Angeles *Herald-Express*, April 24, 1937.)

"Because he assertedly attempted to 'cash in' on the current educational campaign against venereal diseases, Samuel Fendell, forty-eight, health lecturer, today faced a prison term for alleged violation of the State Anti-Birth Control Statute. Constable Donald Hall signed the complaint against Fendell after he attended a Maxwell lecture in which Fendell collected cash for books listing places where 'a safe method of marriage sex relations might be purchased.' Officers said Fendell, before his lecture, passed out cards, proclaiming he would expose the white slave traffic." (Sacramento *Union*, May 6, 1937.)

"Gland products prescribed under the guise of 'food capsules' are illegal, according to a ruling by Attorney-General U. S. Webb, who was asked to rule on the capsules by Dr. C. B. Pinkham, Secretary of the State Board of Medical Examiners, because he said certain California chiropractors were prescribing them as food. Webb ruled them illegal under sections of the State law, saying that medicine may be prescribed only by registered physicians." (Oakland *Tribune*, May 3, 1937.)

"Free on \$3,000 bail, Mrs. Laura Miner, thirty-eight, who surrendered today in Justice Phil Smith's court, today was planning a defense to charges of murder preferred against her yesterday, as the result of the alleged operation death of Mrs. Loretta Hazel Reese, twenty-one, wife of a naval sailor. Warrant for the woman's arrest called for no bail, but it was pointed out to Smith by defense counsel that the woman is the mother of two children, has lived in San Diego for five years, and previously, when charged with merely performing an illegal operation, did not flee when out on \$1,000 bail. ... Mrs. Reese died Wednesday night. She had been in the county hospital since April 21. ... An autopsy performed yesterday by Dr. F. E. Toomey, Coroner's Surgeon, showed that Mrs. Reese's death was caused by an infection resulting from an operation, it was reported." (San Diego *Tribune*, April 30, 1937.)

"'Lack of evidence' was the reason given by Police Judge Joseph A. Kennedy for the dismissal of charges against Dr. J. C. Coleman, negro physician and surgeon, that he had 'conspired to commit an illegal operation' on Mary Lombard, who died some weeks ago. Charges had been brought against Coleman by Raymond Lombard of 1391 Twenty-first Street, father of the 19-year-old girl. James Simpson, 902 Linden Street, a witness, refused to testify on grounds that he might incriminate himself." (Oakland *Post-Inquirer*, April 26, 1937.)

(Continued in Front Advertising Section, Page 20)

†The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.



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The *all-metal* Vacoliter tamper-proof seal must be torn off . . . destroyed . . . before you can use the Vacoliter. When you open a Vacoliter you record your act unmistakably.

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SPOKANE SURGICAL SUPPLY CO., *Spokane*

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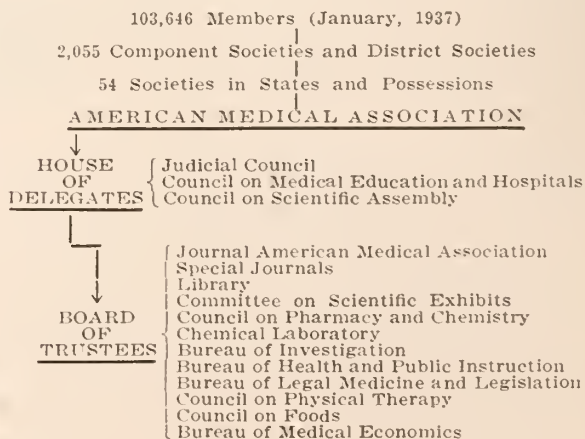
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American Medical Association: Nature of the Organization.—This would seem to be an opportune place in this series of articles to explain the nature of the American Medical Association and its organization. All authority in the American Medical Association derives from its members. The organization is diagrammed below. Membership in a local (district or county) medical society carries with it, automatically, membership in the state medical society and the American Medical Association. Fellowship in the American Medical Association is separate from membership, and brings the member THE JOURNAL or one of the special journals, participation in the scientific work of the Association, eligibility to office, and other privileges.

Groups of county societies form councilor districts, varying in number in the several states, from which councilors are elected for the state society. Delegates are elected by the county societies to the House of Delegates





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President

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FRANK SCHMIDT
Superintendent

of the state society. The delegates determine the policies; the officers carry them out. In similar manner the state societies elect delegates to the House of Delegates of the American Medical Association. The House meets annually at the time of the Scientific Assembly and may be called in special session.

This democratic form of organization, closely resembling that of the United States Government, which is a federation just as is the American Medical Association, is important. It distinguishes the organization of the medical profession from organizations governed in less representative fashions.

Policies of the American Medical Association, determined through the deliberations of the House of Delegates after full and free discussion, are of the utmost importance to the public, because they go far to determine the character of medical practice, of medical education, of hospitalization, of the fight against charlatanism within and without the profession, and of direct services rendered to the public through the service bureaus of the Association. The outlines of the work of the various councils and bureaus which will follow indicate briefly how the fundamental consideration of the medical profession in America, as expressed through the American Medical Association, has been the welfare of the patient.

Responsible directly to the House of Delegates are four principal bodies, the Board of Trustees, the Judicial Council, the Council on Scientific Assembly, and the Council on Medical Education and Hospitals. The other councils and bureaus are also responsible to the House of Delegates, but through the Board of Trustees instead of directly.

The Board of Trustees carries out the policies adopted by the House of Delegates, conducts the business affairs of the Association, and exercises general supervision of the work of the bureaus and councils.

The Judicial Council of the Association interprets the actions of the House of Delegates on matters of policy and procedure, and especially of ethics. Medical ethics, based on the ancient oath of Hippocrates, are modified

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from time to time to meet changing conditions. Such modifications are suggested by the Judicial Council and approved by the House of Delegates. Primary jurisdiction in questions of unethical conduct is local, but the Judicial Council acts as a court of appeal from local and state decisions.—*Journal A. M. A.*

Medical Practice Acts: Prescribing Over the Radio; Prejudice of Members of Board in Revocation Proceedings.—A complaint was filed with the Kansas State Medical Board April 28, 1930, seeking the revocation of Dr. John R. Brinkley's license to practice medicine in that state. The complaint contained eleven specific charges of fraud, immorality and unprofessional conduct. One charge was that Brinkley performed a "compound operation" on patients for the purpose of curing impotence, high blood pressure, epilepsy, dementia praecox, and diseases of the prostate gland and kidneys, and that the operation was of no value to patients. Another charge was that Brinkley gave talks over the radio "for the purpose of enticing patients to his hospital and to induce persons to purchase medicines; that he diagnoses and prescribes for patients over the radio; that he gives prescriptions by numbers which have to be filled by and purchased at certain drug stores, from which he obtains a commission; . . . that such diagnosing and prescribing by radio are necessarily inaccurate and dangerous, carrying too great a hazard of error in misinterpretation of symptoms, inaccuracy or patients' statements of the location and character of complaints, the risk of misunderstanding the respondent's directions and confusion of numbers given of prescriptions, and lacking entirely in the information to be gained by the usual ordinary routine physical and laboratory examination of the patients, without doing which respondent is grossly negligent."

Brinkley was given notice of the charges and a hearing was held July 15, 1930. The hearing, with some adjournments, lasted until September 16 and included a session

(Continued on Next Page)

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(Continued from Preceding Page)

at which Brinkley performed the "compound operation" in the presence of the Board. On September 17, 1930, the Board revoked Brinkley's license and on December 30, 1931, he instituted proceedings in the United States District Court, District of Kansas, to set aside the revocation order on the ground that it invaded rights guaranteed to him by the Federal Constitution. The district court, after a long trial, dismissed the action July 15, 1935, and Brinkley appealed to the United States Circuit Court of Appeals, Tenth Circuit.

Does this record disclose, asked the Court, no more than a conflict of opinion among reputable surgeons as to the technique of operative procedure or as to when it is indicated? Or does it disclose that Brinkley was using his license to perpetrate a cruel hoax on the public by exacting extravagant fees for a trivial and worthless operation? Did Brinkley endanger the health of his patients by seducing them into the belief that serious diseases could be cured by a surgical hocus-pocus? Whether it is the one or the other, the Court said, is a question peculiarly for the decision of men skilled in anatomy. There is, observed the Court, a great volume of evidence in the record to support the latter conclusion; and if such is the fact, the Board would have been derelict if Brinkley's license had not been revoked. It is true that the great advances in medical science have come about by the courage of pioneers, whose efforts often met with ridicule from their professional brethren. It is true that physicians even yet disagree. It is also true that charlatans masquerading as physicians defraud the public, to their own enrichment, by promising to cure cancer with innocuous ointments and thus endanger the lives of their patients by depriving them of sound medical advice. Between these two extremes there is a twilight zone where doubts might perplex. But unless it can be said, from the record, that there is no doubt that this is a mere disagreement among physicians, the finding of the Board is not open to review. The Legislature had properly committed the vital question of the fitness of those who administer to the sick to

a skilled board of medical men and not to courts unlearned in the art. The proof here, the Court said, amply supports the conclusion that the "compound operation" was not an honest effort to relieve suffering, but a scheme for Brinkley's unjust enrichment.

Through regular broadcasts, continued the Court, Brinkley diagnosed almost every ailment to which the human flesh is heir. Sometimes he told his patients to consult a physician; much more often he prescribed remedies, by numbers, which could be obtained from drug stores throughout the Middle West, to whom he had furnished the prescriptions and from whom he received a part of the price of some of the prescriptions. These diagnoses were made without an examination of the patient, and on only such symptoms as the patient would give in a letter or telegram. One need not be skilled in medicine, the Court said, to understand the grave dangers to human life involved in diagnosis and prescription on such sketchy facts as are obtainable from a letter or a telegram; nor of the danger to thousands of others listening in who apply such advice to their own self-diagnosed diseases. It is no answer to suggest that the prescriptions were harmless in themselves; to prescribe bread pills to a diabetic patient whom insulin might save is to trifle with human life. The trial court aptly said:

"Those methods are not only in conflict with the ethics of the profession but are, in my opinion, in conflict with the best interests of the public, and that irrespective of the value of the operations performed by him at the hospital for the amelioration of the prostate gland or of the benefits to individuals urging prescriptions given through radio broadcasting, the possibilities of injury to the general public resulting from such methods are so apparent if such practice became general and usual that its mere statement is, I think, sufficient."

It was for men trained in medicine instead of the law to determine whether Brinkley's conduct constituted unprofessional conduct. The Board of Medical Examiners

(Continued on Page 38)

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(Continued from Page 36)

determined that it did so constitute and there was, the Court said, substantial evidence to support its finding.

The members of the board, Brinkley contended, were prejudiced against him before the hearing started, and some of them were active in instigating the complaint. Without detailing the evidence, the Court said, it does appear that some of the members of the board had expressed such prejudice, and doubtless all were in fact prejudiced. The publicity used by Brinkley, in the opinion of the court, made public prejudice well-nigh inevitable. At any moment the program on the radio might change from cowboy songs to the diagnosis of disease and the extolling of the "compound operation." That the members of the board had radios in their homes constituted no constitutional disqualification. One of the issues of the case was whether the radio talks were in fact given and whether they violated professional standards of conduct. The members of the board having radios thus had personal knowledge of the facts alleged, and necessarily formed some opinion as to whether they were in conflict with professional standards. The Medical Practice Act provided only one tribunal with power to revoke a physician's license. If such powers may not be exercised if the members of the board are prejudiced, then any physician who commits an offense, so grave that it shocks every right-thinking person, has an irrevocable license to practice his profession if he can get the news of his offense to the Board before the hearing begins. This will not do, the Court said. The commendable efforts of the medical profession to raise its standards by cleaning its own house cannot be set at naught by any such rule of law. The trial court, after patiently hearing the evidence as to the attitude of mind of the individual members of the board, disposed of the contention in this language:

"Under the general terms of the statute, the Medical Board is empowered to protect the public against conduct which is clearly against public interests and, therefore, necessarily unprofessional, the same as if the Legislature had specifically denounced and prohibits such practice.

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The members of the board were not disqualified because they knew of his methods prior to the hearing and condemned them. John R. Brinkley's methods were so notorious that ignorance of them by members of the board was an impossibility and such knowledge compelled condemnation."

With this holding, the Circuit Court of Appeals expressed itself as in entire accord.

After reviewing the entire record, at length, the Circuit Court of Appeals concluded that Brinkley's constitutional rights were not infringed. The judgment of the district court against Brinkley was, therefore, affirmed. (*Brinkley vs. Hassig*, 83 F. (2d) 351.)—*Journal A. M. A.*

Malpractice: Criteria of Standard of Skill and Care Required of Physicians.—The Columbia Health Foundation sold "health and medical services and hospitalization" for a stipulated sum per month. The Angelus Hospital Association, also referred to in the record as R. B. Jenkins, Inc., operated a hospital wherein it "took care of the customers" of the Health Foundation for a stipulated sum. Dr. R. B. Jenkins was the president of the corporation hospital, the principal owner of its stock, and its general surgeon. The plaintiff was apparently a "customer" of the Health Foundation and his wife was admitted to the hospital for her confinement. The baby developed impetigo and subsequently died, whereupon the plaintiff sued the Health Foundation, the hospital corporation, and certain physicians employed by the hospital, alleging negligence in permitting the baby to contract impetigo, in treating it thereafter, and in discharging the plaintiff's wife and her baby at a time when the baby was still suffering from "an acute attack of impetigo." The plaintiff obtained judgment against all the defendants, who, with the exception of those connected with the Health Foundation, appealed to the District Court of Appeal, Second District, Division One, California.

The principal issue raised on appeal had relation to the form in which a certain hypothetical question was put to

(Continued on Page 41)

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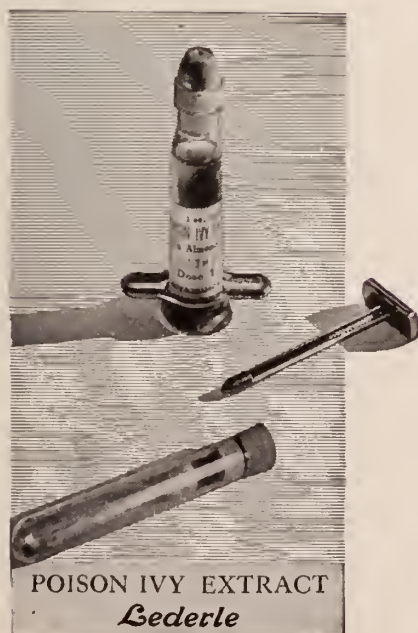
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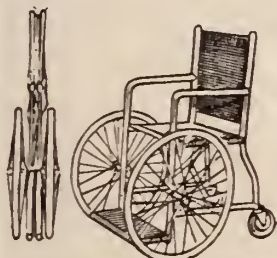


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(Continued from Page 38)

an expert witness for the plaintiff. The vice attributed to the question was that it sought from the witness an opinion as to whether the particular physician whose alleged negligence was at issue had exercised that degree of skill, care and learning ordinarily possessed and exercised by physicians and surgeons practicing in Los Angeles in the treatment of similar conditions. Technically, said the Court, the appellants' objection was correct. When a hypothetical question is put to an expert witness the evidence sought is not what the witness personally thinks of what was or was not done, not whether he would do or omit to do the particular act or omission charged as negligence, not whether the actual physician in the case was negligent in the commission or omission charged, but whether, in the opinion of the witness, a physician of ordinary attainments practicing in the same locality and using ordinary skill and care would have done or failed to do the thing charged. An expert witness, continued the Court, gives his opinion with respect to whether the doing or not doing of a certain thing conforms to what a hypothetical physician, endowed with ordinary skill and learning and exercising ordinary care and prudence, practicing in the locality in question, would or would not do. Such an opinion, in legal supposition, is different from saying that the actual physician in a given case is skilled or unskilled, careless or careful. The expert's opinion sets up for the use of the jury or the court a hypothetical physician, by which the jury or court may test the skill of and the care used by the physician actually involved. While the hypothetical question propounded in this case did seek to elicit from the expert witness an opinion as to whether or not the particular physician exercised the required degree of care, the Court was of the opinion that the objectionable form of the question did not constitute prejudicial error because, in answering the question, the witness stated: "The treatment differs from the usual treatment of these conditions." This answer, the Court said, gave the jury exactly the information that the question should have called for if it had been framed correctly. While the question was incorrectly framed, the answer itself did not constitute an invasion of the province of the jury.

The appellants contended also that the plaintiff's contract called only for obstetric services to the plaintiff's wife and did not require any care for the baby. Such a distinction, the Court said, is too strained to be substantial. When an obstetrician undertakes to deliver a woman of a baby, he may not devote his entire attention at the time and

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during the hospital confinement to the mother alone. It should be said, pointed out the Court, in justice to the physicians involved in this case, that they undoubtedly felt under obligation to care for the baby, since they did proceed to look after it.

The record in this case, concluded the Court, substantially supported the jury's verdict for the plaintiff. The judgment of the trial court was, therefore, affirmed. (*Criss vs. Angelus Hospital Association of Los Angeles* (Calif.), 56 P. (2d) 1274.)—*Journal A. M. A.*

Fewer Rats in Large Cities.—Twenty years ago there was one rat for every person in almost all the large cities. Today it is estimated there is not more than one rat to each two persons in such cities, says the United States Department of Agriculture, in a new circular, "The House Rat." In small towns, however, the number of rats is estimated equal to the human population and on farms the ratio is much greater.

There are fewer rats in large cities because of improved sanitary conditions, modern rat-proof construction, fewer horses, improved food packages, and fewer waste food products.

Prepared by James Silver of the United States Bureau of Biological Survey, the circular points out that, because of

(Continued on Next Page)

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(Continued from Preceding Page)

the normally abundant food supply and many rat harbors, there are few rat-free farms. In some of the control campaigns several hundreds, and even thousands of rats, have been taken from farms. Some years ago the contestants in a rat-killing campaign in one county in Texas turned in 153,720 rat tails in six weeks. The human population of the county was only 35,000.

Rat control in the smaller agricultural towns is usually more difficult than in large cities because proportionately less concrete is used than in cities, and facilities for disposing of garbage and trash often are lacking.

Both species of the house rat, the brown and black, immigrated from Europe on ships. As the black rat is the common ship rat, it is quite likely it was introduced at the time ships first moored on American shores. It is now found chiefly at seaports and in the Gulf States. The brown rat is reported to have made its first appearance in the United States about the beginning of the American Revolution—in 1775. From various seaports it gradually spread inland, driving out the smaller black rat, until now it is common in every state.

Today it is estimated there are 123,000,000 rats in the United States—almost as many rats as persons. Half the total is estimated to be on farms; 34,000,000 on nonfarm country residences and in towns with less than 10,000 population, and 29,000,000 in cities of 10,000 or more. The circular says rats cause an estimated annual loss of \$189,000,000. Of this sum, \$63,000,000 is lost on farms, an average of \$10 per farm; \$68,000,000 in small towns and on nonfarm residences, and \$58,000,000 in large cities.

Rats carry bacteria and parasites and a number of their own diseases are transmissible to man and domestic animals. In addition, they contract and spread some human and livestock diseases.

Poison bait prepared with red squill is primarily recommended for control, not only because it kills the animals but because it is relatively harmless to humans and domestic animals. Rat killing should be followed by elimination of their harbors and the rat proofing of buildings.

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Detailed instructions for preparing and distributing red-squill baits and for gassing, trapping, and otherwise suppressing rats are given in Farmers' Bulletin 1533, "Rat Control." Methods of shutting rats out of buildings and premises are described in Farmers' Bulletin 1638, "Rat Proofing Buildings and Premises." Copies of these publications and of the new Circular No. 423, "The House Rat," may be obtained at five cents each from the Superintendent of Documents at Washington, D. C.

Fight Against Gonorrhea Must Follow Campaign to Stamp Out Syphilis in War on Venereal Diseases.

With the campaign to stamp out syphilis now well under way in the United States, a national effort to control the widespread prevalence of gonorrhea is the next step that must be undertaken in the fight against venereal diseases, in the opinion of Dr. William F. Snow, General Director of the American Social Hygiene Association, 50 West Fiftieth Street, New York.

"The health authorities and the medical profession cannot hope to carry out effectively the necessary practical programs in attacking these diseases unless the general public clearly understands and fully supports them with adequate appropriations and the active cooperation of individual citizens." Doctor Snow emphasizes this fact in a special number of the *Journal of Social Hygiene*, which reviews the findings of the recent Conference on Venereal Disease Control Work held in Washington, D. C., under the chairmanship of Dr. Thomas Parran, Surgeon-General of the United States Public Health Service.

Although the conference in Washington rightly concentrated attention upon syphilis, which is the problem of immediate concern, the public should know that gonorrhea is the next to go, Doctor Snow explains. It has been estimated that approximately six million men, women and children are suffering from syphilis in the United States and that more than twelve million persons have gonorrhea.

An editorial in the *Journal of Social Hygiene* compares the plans for a successful fight against syphilis, and the

(Continued on Page 44)



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A. H. WARNER, Ph. D.**

(Continued from Page 42)

little being done about gonorrhea, with a baseball game in which the pitcher strikes out the man at bat but loses the game because the men on bases were allowed to make runs.

"It would seem that by the sheer weight of the misery which gonorrhea produces throughout the world, it would force itself upon public notice," says Dr. P. S. Pelouze, Professor of Urology at the University of Pennsylvania, in a report on the medical measures which are needed for adequate control of gonorrhea. These are a few of the points to which he calls attention:

The incidence of gonorrhea is at least twice and probably three or four times that of syphilis. What it may lack in ability to cripple and kill, it makes up easily in numbers. It may be acquired repeatedly and thus become a recurring cause of economic loss and poor health.

The sterility which so frequently follows infection with gonorrhea forever denies parenthood to countless men and women who desire to be fathers and mothers.

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There is no treatment known today that lends itself to mass application, and quickly renders the patient non-infectious. In the male the disease is practically one hundred per cent curable, and in the female it should be almost as much so. But no one can predict just how long each case will require treatment to reach the point of cure.

From a public health point of view it is necessary to recognize that gonorrhea is a disease that can be transmitted to others as long as there is a single gonococcus present. It is a disease the cure of which is dependent upon the patient's ability to develop certain curative responses.

At no time has there been greater general medical interest in gonorrhea than exists today. Treatment has improved, so that the complications formerly seen so frequently have been largely eliminated.

Compensation of Physicians: Oral Promise by Daughter to Pay for Services Rendered Father.—The plaintiff, a physician, answered an emergency call from an unknown source to attend a man severely injured in an automobile accident. When he arrived at the scene of the accident, a daughter of the injured man requested him, according to the evidence, to "do everything you can under the sun to see this man is taken care of . . . and what the charges are . . . I will pay for it." The plaintiff did treat the injured man until the following morning, when his services were discontinued at the request of the daughter. The injured man died several days later from the effects of the injury. The plaintiff attempted first to collect his fees from the estate of the deceased. Being unsuccessful, he, about a year after the accident, began sending bills to the deceased's widow. Finally, about a year and a half after the accident, the plaintiff instituted the present suit against the defendant, the daughter of the deceased. The trial court directed a verdict for the defendant and the plaintiff sought a reversal in the Supreme Court of Vermont.

The defendant's relations with her father, said the Supreme Court, were such that she was not liable for the



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plaintiff's services unless she became so by reason of what she said or did. The rule is well established that a person who merely calls a physician to render services to another is not liable therefor in the absence of an express agreement, unless the person is legally bound to furnish such services. The defendant in this case did, according to the evidence, promise to pay for the services, and ordinarily, said the court, this promise might make an entirely different case for the plaintiff. It showed not only that the defendant requested the services, but also that she made a direct promise to pay for them. Such a promise is not collateral or secondary, but primary and original. It is not a promise to pay the debt of another, but is a promise to pay the debt of the promisor and does not have to be in writing to be valid. But, said the court, when the defendant made the promise, the plaintiff was at liberty to accept or reject it. He could, if he chose, treat the injured man on his own credit. He could not, however, hold both the injured man and the defendant liable for his fees. If he gave credit to the injured man, he could not collect from the defendant, even though she had tendered an engagement direct in form. The defendant's sole obligation could not be treated by the plaintiff as a joint obligation without her concurrence. If the plaintiff gave any credit to the injured man, he elected to accept the defendant's engagement as collateral to that of the injured man. The plaintiff did, the court pointed out, make his original charges against the injured man and it must be assumed that he did so because he considered the injured man responsible for his fees. Having given credit to the injured man, the plaintiff may not, the court concluded, collect from the defendant. The judgment of the trial court was therefore affirmed. (*Lawrence vs. Anderson* (Vt.), 184 A. 689.)—*Journal A. M. A.*

be operating and thirty-four in the state of established proposals. Fourteen new plans have recently been proposed. Thus the present status may be defined as one of active experimentation in an effort to find out the workable features and thus maintain systems capable of meeting existing needs. Various investigations indicate that somewhere between 500,000 and 700,000 persons are now members of such plans. Incidentally, three plans have 50 per cent of the entire membership, and ten plans have 80 per cent of the entire membership. In Chicago the plan proposed through the Hospital Council involved the setting up of a hospital service corporation as a nonprofit corporation, organized under the Illinois act exempting a nonprofit service corporation from the insurance code of the state. This plan has been under active consideration by a committee of the Chicago Medical Society, which proposed six requirements before it could place the approval of the Chicago Medical Society on the plan. Of these, the chief demand is that all matters of medical administration and medical policy be referred to the Chicago Medical Society, whose decision in these instances shall be final and binding both on the Chicago Hospital Council and on its member hospitals. Unfortunately, the Council of the Chicago Medical Society has not yet accepted the report of its committee, owing to the apparent insistence of one of its members that the medical society do not enter into the arrangement unless it has a guaranty of 51 per cent of the directorate, an insistence to which the Hospital Service Corporation may hesitate to consent. It is interesting to realize that Chicago has already had ten group hospitalization plans besides the Hospital Service Corporation, not one of which has attained even slightly significant proportions. Two of these plans were organized under the same law that created the Hospital Service Corporation and both secured articles of incorporation notwithstanding the fact that they were promoted by hospitals considered to be unable to give first-class service. Another unfortunate aspect of the situation is the fact that the propaganda and promotion associated

Hospital Insurance Plans.—Out of 172 group hospitalization and hospital insurance plans recently addressed by the Bureau of Medical Economics of the American Medical Association, ninety were found active and eighty-two inactive. Of the active plans, fifty-six were found to

(Continued on Next Page)



Suction Irrigation in Sinus Conditions

as suggested by Harold Hays, M. D., F. A. C. S., New York

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"Conservative Treatment of the Nasal Sinuses," N. Y. State Jr. Med., Jan. 15, 1937, by Harold Hays, M. D. "Sinusitis—Shall Treatment be Surgical or Non-Surgical," Eye, Ear, Nose and Throat Monthly, Sept., 1936, by Irving Voorhees, M. D.

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(Continued from Preceding Page)

with the Hospital Service Corporation have brought into the field various unethical imitators, one of them advancing himself by the circularization of the public in his vicinity with a schedule labeled "the Chicago Hospital Service Plan," a vague imitation of the proposition advanced by the Hospital Service Corporation. It will apparently become the obligation of those who actively promote such plans under legitimate auspices to protect the public at the same time against illegitimate promoters, through exercising the rights of any business group to the protection of their names and style in the courts.—*Journal A. M. A.*

State Medicine in Britain: "An Avalanche of Papers."

Physicians have endeavored repeatedly to convince the public that practice under social insurance interferes with the giving of adequate time and attention to patients. The then becomes his duty to study all the various memorandum suggestion has been ventured that the necessary study and paper work associated with practice under government auspices was in itself a chore and a time-consuming performance. Now concrete evidence of the nature of such work becomes available through a brief item with the title "An Avalanche of Papers" in the supplement of the *British Medical Journal*.* When an insurance practitioner is appointed he receives from the headquarters the following items:

1. Prescription books.
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4. The Medical Benefit Regulations.

5. The Drug Tariff.
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7. Memorandum on Pregnancy and Parturition of Insured Married Women.
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11. Report on the Definition of Drugs for the Purpose of Medical Benefit.
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These items are sent to a practitioner who may have had no previous experience of insurance medical practice. It dums and to learn how to fill out all the various forms of application cards, requisition forms, and the nine other forms that are listed.

The *British Medical Journal* comments that "there is no guide or index and we can well imagine a practitioner being bewildered as to which document he should consult to enable him to determine his course of action in relationship to the problem with which he is faced." In fact, the entire business is so complicated that a special form has now been prepared with a view to serving as a guide book through this maze of bureaucratic red tape.—*Journal of the American Medical Association* March 27, 1937.

* An Avalanche of Papers, Brit. M. J. Supplement, March 6, 1937, page 115.



UNTIL another Ehrlich appears on the scene, the arsenicals probably are destined to remain the foundation of antisyphilitic therapy.

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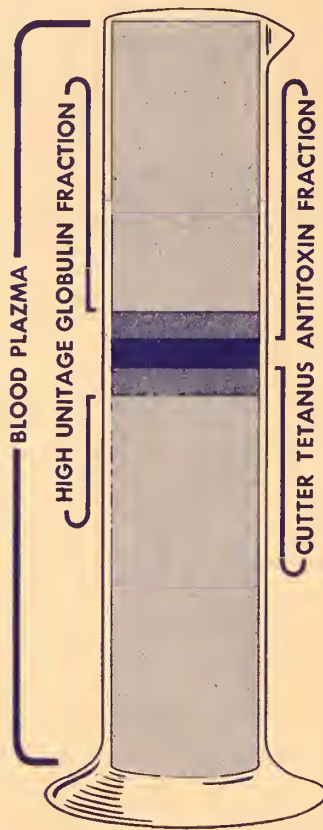
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